SERFF Tracking Number:	*UHLC-126036498*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41573*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002C Large Group Only - Other*
Product Name:	*2009 UnitedHealthcare Senior Supplement*		
Project Name/Number:	*2009 UnitedHealthcare Senior Supplement /*		

Filing at a Glance

Company: United HealthCare Insurance Company

Product Name: 2009 UnitedHealthcare Senior Supplement	SERFF Tr Num: UHLC-126036498	State: ArkansasLH
TOI: H16G Group Health - Major Medical	SERFF Status: Closed	State Tr Num: 41573
Sub-TOI: H16G.002C Large Group Only - Other	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Authors: Judith Davenport, Martha Blanke, Becky Kieran	Disposition Date: 02/20/2009
	Date Submitted: 02/17/2009	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: 2009 UnitedHealthcare Senior Supplement	Status of Filing in Domicile: Pending
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Large
Overall Rate Impact:	Group Market Type: Employer, Association
Filing Status Changed: 02/20/2009	Explanation for Other Group Market Type:
	State Status Changed: 02/20/2009
Deemer Date:	Corresponding Filing Tracking Number:

Filing Description:

Please refer to the Cover Letter on the Supporting Documentation tab for the details of this large group major medical health policy. We thank you for your time and consideration of this filing.

Company and Contact

SERFF Tracking Number:	*UHLC-126036498*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41573*
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Product Name:	*2009 UnitedHealthcare Senior Supplement*		
Project Name/Number:	*2009 UnitedHealthcare Senior Supplement /*		

Filing Contact Information

Judith Davenport, Manager
5995 Plaza Dr.
Cypress, CA 90630

judy.davenport@phs.com
(714) 226-3507 [Phone]
(714) 226-3238[FAX]

Filing Company Information

United HealthCare Insurance Company
450 Columbus Boulevard
PO Box 150450
Hartford, CT 06115-0450
(215) 653-8046 ext. [Phone]

CoCode: 79413
Group Code: 707

Group Name:
FEIN Number: 36-2739571

State of Domicile: Connecticut
Company Type: Life and Health

State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	Fee for filing new product policy forms.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United HealthCare Insurance Company	$50.00	02/17/2009	25764804

SERFF Tracking Number:	*UHLC-126036498*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41573*
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Project Name/Number:	*2009 UnitedHealthcare Senior Supplement /*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	02/20/2009	02/20/2009

SERFF Tracking Number:	*UHLC-126036498*	*State:*	*Arkansas*
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Project Name/Number:	*2009 UnitedHealthcare Senior Supplement /*		

Disposition

Disposition Date: 02/20/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*UHLC-126036498*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41573*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002C Large Group Only - Other*
Product Name:	*2009 UnitedHealthcare Senior Supplement*		
Project Name/Number:	*2009 UnitedHealthcare Senior Supplement /*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Form	Group Health Insurance Policy	Approved-Closed	Yes
Form	Group Health Insurance Certificate	Approved-Closed	Yes
Form	Schedule of Benefits	Approved-Closed	Yes
Form	Hearing Benefit Rider	Approved-Closed	Yes
Form	Vision Benefit Rider	Approved-Closed	Yes
Form	Neuromuscular Skeletal Disorder Benefit Rider	Approved-Closed	Yes
Form	Outpatient Prescription Drug Rider	Approved-Closed	Yes
Form	Consumer Information Notice	Approved-Closed	Yes
Form	Guaranty Association Notice	Approved-Closed	Yes

SERFF Tracking Number:	*UHLC-126036498*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41573*
Company Tracking Number:			
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Product Name:	*2009 UnitedHealthcare Senior Supplement*		
Project Name/Number:	*2009 UnitedHealthcare Senior Supplement /*		

Form Schedule

Lead Form Number: SRINS-POL

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	SRINS-POL	Policy/Contract/Fraternal Certificate	Group Health Insurance Policy	Initial		48	SRINS-POL.pdf
Approved-Closed	SRINS-CERT-AR	Certificate	Group Health Insurance Certificate	Initial		45	SRINS-CERT-AR.pdf
Approved-Closed	SRINS-SOB	Schedule Pages	Schedule of Benefits	Initial			SRINS-SOB.pdf
Approved-Closed	SRINS-HR-AR	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Hearing Benefit Rider	Initial		43	SRINS-HR-AR.pdf
Approved-Closed	SRINS-VR	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Vision Benefit Rider	Initial		46	SRINS-VR.pdf
Approved-Closed	SRINS-NMSR	Policy/Contract/Fraternal Certificate: Amendment, Insert	Neuromuscular Skeletal Disorder Benefit Rider	Initial		43	SRINS-NMSR.pdf

SERFF Tracking Number:	*UHLC-126036498*		*State:*	*Arkansas*			
Filing Company:	*United HealthCare Insurance Company*		*State Tracking Number:*	*41573*			
Company Tracking Number:							
TOI:	*H16G Group Health - Major Medical*		*Sub-TOI:*	*H16G.002C Large Group Only - Other*			
Product Name:	*2009 UnitedHealthcare Senior Supplement*						
Project Name/Number:	*2009 UnitedHealthcare Senior Supplement /*						
Approved-Closed	SRINS-RX	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Outpatient Prescription Drug Rider	Initial		41	SRINS-RX.pdf
Approved-Closed	SRINS-CONSINFO-AR	Other	Consumer Information Notice	Initial			SRINS-CONSINFO-AR - Consumer Information Notice Form.pdf
Approved-Closed	SRINS-GFNOTICE-AR	Other	Guaranty Association Notice	Initial			SRINS-GFNOTICE-AR - Guaranty Assoc Notice.pdf

UNITEDHEALTHCARE INSURANCE COMPANY
(the "Company")
[450 Columbus Blvd.
P.O.Box 150450
Hartford, CT 06115-0450]

GROUP HEALTH INSURANCE POLICY

UnitedHealthcare Insurance Company (the "Company") will provide the Policy benefits to each Covered Person in consideration and acceptance of the Group Policyholder's [application and] premium, and subject to all Policy provisions.

The Policy becomes effective on the Policy Effective Date shown on the Policy Information Page and [continues in force until the first anniversary of the Policy Effective Date] [continues in force until January 1of the following year], unless it terminates earlier as provided herein. Thereafter, the Policy remains in force for twelve (12) months [beginning on each following anniversary of the Policy Effective Date] [beginning each January 1], subject to the Policy Termination section.

The Policy is delivered in and governed by the laws of the State of Arkansas.

Signed for by UnitedHealthcare Insurance Company at our Home Office in Hartford, Connecticut

UNITEDHEALTHCARE INSURANCE COMPANY

[Allen J. Sorbo]
President

TABLE OF CONTENTS
SECTIONS

Policy Provisions Page Number

GENERAL PROVISIONS

CERTIFICATE. [The Group Policyholder will receive individual Certificates for delivery to each Insured Person.] [The Company will deliver Certificates to each Insured Person.] These Certificates summarize the benefits provided by this Policy. If there is a conflict between the Policy and the Certificate, the Policy will control.

CLERICAL ERROR. Clerical error does not invalidate insurance otherwise validly in force, nor continue insurance otherwise validly terminated. Neither the passage of time nor the payment of premiums for a person who is not eligible for insurance under the terms of the Policy makes the insurance valid for such person. In this event, the Company's only liability is the proper refund of unearned premiums. If a premium adjustment requires the refund of unearned premium, the maximum refund is the six (6)-month period preceding the date the Company receives proof of the adjustment. The Company can request such information while the Policy is in force and for one (1) year after the Policy ends.

CONFORMITY TO STATE AND FEDERAL LAW. The Company amends any provision of the Policy that conflicts with state or federal law on the Policy Effective Date to the minimum requirements of the law.

CONSENT OF COVERED PERSON NOT REQUIRED. The Policy shall be subject to amendment, modification or termination per Policy Provisions without the consent of Covered Person.

DEFINITIONS. The Certificate provides the definitions of terms used in the Policy.

ENTIRE CONTRACT. The Policy, the Application for Group Coverage, the attached copy of the Certificate, the Schedule of Benefits, and the Insured Persons' Enrollment Forms, if any, constitute the entire contract between the parties. All statements made by the Group Policyholder and by Insured Persons are representations not warranties. A statement from the Insured Person will only support a contest of the coverage provided by the Policy when the Company provides a copy of the statement to the Insured Person.

Only an officer of the Company may change the Policy or extend the time for payment of any premium. No change will be valid unless made in writing and signed by an officer of the Company. Any change so made will be binding on all Persons referred to in the Policy. No agent has the implied or expressed authority to determine insurability, make any contracts in the name of the Company, or cancel, alter or amend any provision of the Policy.

GROUP POLICYHOLDER NOT OUR AGENT. The Group Policyholder is not an agent of the Company.

LEGAL ACTIONS. Any person may not bring legal action for benefits against the Company:

1. Until at least sixty (60) days after proof of loss is sent to the Company as required; or
2. More than three (3) years after the time for submitting proof has ended.

MISSTATEMENT OF AGE. Misstatement of the Covered Person's age will subject premiums to an equitable adjustment. If the amount of benefit is dependent upon age, the benefit will be that which would have been payable based upon the Covered Person's correct age.

NOT IN LIEU OF WORKERS' COMPENSATION. The Policy is not instead of, and does not impact any requirement for coverage by Workers' Compensation Insurance.

RECOVERY RIGHT DUE TO CLERICAL ERROR. When payments made under the Policy are due to clerical error, the Company has the right to recover any such payment it made in error. The Company has the right to recover from the person an amount equal to the amount paid by the Company.

RIGHT TO RECEIVE INFORMATION. The Group Policyholder shall provide the Company with the information necessary to administer coverage under the Policy. Payroll and any other records of an Insured Person relating to coverage under the Policy shall be open for review by the Company at any reasonable time. The Company may request that information needed to compute the premium be furnished at least once each year.

TIME EFFECTIVE. Whenever an Effective Date of coverage is specified by the Policy, such commencement of coverage will be effective as of 12:00 a.m. of that date.

TIME LIMIT ON CERTAIN DEFENSES. The validity of insurance shall not be contested because of any statement, except fraudulent misstatements, with respect to insurability made by any person, after the insurance has been in force for [two (2)] years during the Covered Person's lifetime.

WAIVER OF RIGHTS. The Company's failure to enforce any provision of the Policy does not affect the Company's right to enforce any provision at a later date, and does not affect the Company's right to enforce any other provision of the Policy.

PREMIUM PROVISIONS

PAYMENT OF PREMIUMS. The insurance provided by the Policy is not in effect until the Company accepts [the Application for Group Coverage and] the first premium payment for such insurance. Each following premium payment is payable on or before the due date for insurance to remain in effect. [The [Group Policyholder] [Retiree] [Group Policyholder and Retiree are] [is] responsible for paying all premiums as they become due.] Premiums are payable on or before the Premium Due Date, unless the Company agrees to some other mode of payment. Premiums are payable to the Company at its Home Office.

PREMIUM RATE CHANGE. The Company may change any Premium Rate on any of the following dates:

1. after the initial twelve (12) months of coverage; or
2. the date any of the Policy's terms are changed, including any federal or state law or regulation affecting the Company's liability under the Policy.

Unless the Company and the Group Policyholder agree otherwise, the Company will give at least [31- 60] days advance written notice of any change in Premium Rates.

Misstatement of the age, family status or geographic location of an Insured Person and/or Dependent will subject premiums to an adjustment.

GRACE PERIOD. After the first premium payment, the Company shall allow a Grace Period of [31- 60] days following each Premium Due Date. During the Grace Period, coverage under the Policy will remain in effect provided the Company receives the premium before the end of the Grace Period. If any premium is unpaid at the end of the Grace Period, the Policy will terminate in accordance with the Policy Termination section of the Policy.

PREMIUM AMOUNT. [The amount of premium due is the sum of the products obtained by multiplying each rate shown on the Premium Rate Schedule by the number of Persons to which each such rate applies.] [The amount of premium due for each Covered Person can be determined by identifying the plan option selected by the Covered Person and the Covered Person's appropriate area definition and age range.]

POLICY TERMINATION

TERMINATION BY THE COMPANY. The Company may terminate the Policy on any Premium Due Date:

1. for nonpayment of the required premiums;
2. when the Company determines the Group Policyholder has committed fraud or made other intentional misrepresentations;
3. for noncompliance with a material plan provision, including failure to comply with contribution and participation requirements and failure of the Group Policyholder to perform its obligations under the Policy in good faith;
4. when part of the premium is paid by Insured Persons and less than [75%] of those eligible for coverage are insured; or
5. when all of the premium is paid by the Group Policyholder and less than [100%] of those eligible for coverage are insured.

If the Company ceases to write, issue or administer new or existing group health benefit plans in the Group Policyholder's State, all coverage under the Policy will be terminated. The Company will notify the Group Policyholder of this type of termination at least 180 days prior to discontinuation of the coverage under the Policy.

If the Company withdraws the group health benefit plan from the market, all coverage under the Policy will terminate. The Company will notify the Group Policyholder of this type of termination at least 90 days prior to discontinuation of the coverage under the Policy. The Company will offer the Policyholder the opportunity to purchase, without regard to claims experience or health related factors of Covered Persons, any similar plan that the Company has available in the employer group market at the time the Policy is discontinued.

The Policy may terminate on an earlier date when both the Group Policyholder and the Company agree to such termination.

TERMINATION BY GROUP POLICYHOLDER. The Group Policyholder may terminate the Policy at any time by giving notice to the Company. The Policy will terminate on the date the Company receives the notice or some later date on which the Group Policyholder and the Company have agreed. The Group Policyholder is responsible for premium payments through the date of termination.

AUTOMATIC TERMINATION. The Policy will terminate, without any action on the part of the Company, on the day before the due date of any premium that remains unpaid at the end of the Grace Period.

INSURED PERSON NOTIFICATION. In the event of Policy termination, the Group Policyholder is responsible for written notification to Insured Persons of such termination.

PROVIDING MISLEADING OR FRAUDULENT INFORMATION. At its discretion, the Company may terminate or rescind the Policy upon [31- 60] days written notice to the Group Policyholder if the Group Policyholder knowingly provides materially misleading or fraudulent information to the Company on any application documents.

POLICY INFORMATION PAGE

[GROUP POLICYHOLDER:]	[Enter Policyholder Name here]
[POLICY NUMBER:]	[Enter Policy Number here]
[GROUP NUMBER:]	[Enter Group Number here]
[POLICY EFFECTIVE DATE:]	[Enter Policy Effective Date here]
[POLICY ANNIVERSARY:]	[Enter Anniversary Date here]
[CONTRIBUTIONS:]	[Insured Persons make contributions for the following: Personal Health Insurance Yes ☐ No ☐ Dependent Health Insurance Yes ☐ No ☐]
[ELIGIBILITY:]	[Enter Eligibility Information here]
[PREMIUM DUE DATE:]	[Enter Premium Due Date here]
[PREMIUM IS PAYABLE:]	[Enter Payable Information here]
[BENEFIT PLAN(S):]	[Enter Benefit Plans Covered by Policy]

[THE MONTHLY PREMIUM RATE SCHEDULE IS ATTACHED TO THIS POLICY INFORMATION PAGE]

UNITEDHEALTHCARE INSURANCE COMPANY
[450 Columbus Blvd.
P.O.Box 150450
Hartford, CT 06115-0450]

GROUP HEALTH INSURANCE CERTIFICATE
[SECURE HORIZONS]
[SENIOR SUPPLEMENT][SENIOR SECURITY]
[UNITEDHEALTHCARE][RETIREE BENEFIT] [PLAN]

UnitedHealthcare Insurance Company (the "Company") hereby delivers to the Group Policyholder a Policy providing insurance for certain eligible Covered Persons. The Certificate and Schedule of Benefits describe the benefits and provisions of the insurance provided by the Policy.

You may receive the benefits specified in the Certificate and Schedule of Benefits if You are eligible for insurance under the provisions of the Policy.

The Certificate is not a contract of insurance and only summarizes the primary provisions of the Policy. The Certificate supersedes and replaces any similar Certificate that the Company previously issued to You.

The Certificate is valid only if it includes Your Schedule of Benefits.

Any Certificate issued in the State of Arkansas will be governed by Arkansas law.

UNITEDHEALTHCARE INSURANCE COMPANY

[Allen J. Sorbo]
President

Table of Contents

WELCOME TO UNITEDHEALTHCARE

The Company provides health care benefits to Covered Persons who have properly enrolled and meet the Employer's eligibility requirements. To learn more about these requirements, see Section Three: Covered Person Eligibility.

WHAT IS THIS PUBLICATION?

This publication is called a Certificate of Coverage (Certificate). It is a legal document that explains Your health care plan and should answer many important questions about Your benefits. Many of the words and terms are capitalized because they have special meanings. To better understand these terms, please see Section Five: Definitions.

Whether You are the Insured Person for this coverage or enrolled as a Dependent, Your Certificate and Schedule of Benefits are key to making the most of Your coverage.

WHAT ELSE SHOULD I READ TO UNDERSTAND MY BENEFITS?

Along with reading this Certificate and Your Schedule of Benefits, be sure to review any supplemental benefit materials. Your Schedule of Benefits provides the details of Your particular health plan, including any Deductibles, Copayments or Coinsurance that You may have to pay when receiving a health care service. Together, these documents explain Your coverage.

WHAT IF I STILL NEED HELP?

After You become familiar with Your benefits, You may still need assistance. Please don't hesitate to contact Our Customer Service Department as shown below:

- [[By calling 1-XXX-XXX-XXXX] 7:00 a.m. to 9:00 p.m., Monday through Friday]
- [By accessing Our Customer Service Website at [xxxxx@uhc.com]]

NOTE: Your Certificate and Your Schedule of Benefits provide the terms and conditions of Your benefits. These forms should be read completely and carefully. Individuals with special health needs should pay special attention to those sections that apply to them.

You may also correspond with the Company at the following address:

UnitedHealthcare Insurance Company
[P.O. Box XXXX]
[City] [State] [ZIP]
[1-XXX-XXX-XXXX]

[UnitedHealthcare's Website is:]

[www.xxxxxxxxx@uhc.com]

Administrators

Certain provisions of the Certificate are administered by one or more of the Company's Administrators. They are as follows:

[FOR ELIGIBILITY, BENEFITS VERIFICATION, AND PAYMENT OF CLAIMS:

UnitedHealthcare Insurance Company
[P.O. Box]
[CITY] [STATE] [ZIP]
[1-XXX-XXX-XXXX]]

[FOR BENEFITS VERIFICATION AND PAYMENT OF CLAIMS:

UnitedHealthcare Insurance Company
[P.O. Box]
[CITY] [STATE] [ZIP]
[1-XXX-XXX-XXXX]

[Certain non-Medicare Eligible Expenses may require Preauthorization. Failure to obtain Preauthorization will result in a reduction of the benefits payable by the Company for Covered Services as set forth on the Schedule of Benefits.]

[FOR PREAUTHORIZATION OF TREATMENT OR SERVICES:

[1-XXX-XXX-XXXX]]

All inquiries and notifications required by the terms and conditions of the Policy or Certificate are to be mailed or phoned to the Company's Administrator. Notification requirements to the Company are fulfilled by contacting the Company's Administrator in this manner.

- [Preauthorization Requirements]
- Inpatient Benefits
- Outpatient Benefits
- Exclusions and Limitations Of Benefits

This section explains Your medical benefits, including what is and isn't covered by the Company. All Covered Services must be Medically Necessary as determined by the Company. If You have any questions as to whether a service or supply is a Covered Service, please consult this Certificate or contact Us at [1-XXX-XXX-XXXX.] Our Customer Service Department can assist You in determining Your benefits. The Company will evaluate submitted Claims for Medical Necessity, and benefit payments may be adjusted or declined consistent with the evaluation findings. For any Deductibles, Copayments or Coinsurance that may be associated with a benefit, You should refer to Your Schedule of Benefits. [Some services require Preauthorization, have limitations or are excluded from coverage.] Please consult Your Schedule of Benefits and this Section One for an explanation of Your Medical Benefits, as well as the Exclusions and Limitations section of this Certificate. You can also find some helpful definitions in Section Five at the back of this Certificate.

If a specific service or supply is not included in this Section One: Your Medical Benefits, or in any supplemental Benefit Rider purchased by the Covered Person's Employer, it is not a Covered Service and no benefits will be provided under the Policy.

YOUR MEDICAL BENEFITS

The benefits of the Policy described in this Certificate are based on the assumption that the Covered Person is enrolled in Medicare Part A and Part B. The Company will pay the following benefits up to the Covered Expense, only to the extent that the Medicare Eligible Expense has not been paid by Medicare and subject to all other limitations and exclusions set forth in the Policy and in the Schedule of Benefits. Covered Persons must use Medicare participating Providers, approved Facilities and approved Hospice agencies.

[[I. Preauthorization Requirements

Covered Persons must comply with the notification requirements and obtain Preauthorization as outlined below to avoid a reduction in benefits under the Policy. The Covered Person must provide the necessary information for review by either calling [1-XXX-XXX-XXXX] or submitting the information in writing.]

[Failure to Preauthorize Services

Failure to comply with the Preauthorization requirements for specified services, other than Medicare-approved services, will result in a reduction of the benefits payable by the Company for Covered Services as shown on the Schedule of Benefits. Any additional Covered Expenses that a Covered Person has to pay due to failure to comply with Preauthorization requirements will not apply toward the Covered Person's [Calendar] [Plan] Year Deductible or Coinsurance Maximum.]

[Emergency

Notification of emergency Inpatient admissions must be made to the Company within [two (2) business days] of admission to a Hospital or Facility.]

[Non-Emergency

Preauthorization must be obtained from the Company [three (3) business days] before the actual date of service for all scheduled non-emergency admissions to a Hospital or Facility and for specified Outpatient procedures and services.]

[The following non-Emergency Services require Preauthorization:]]

[[INPATIENT SERVICES]

- [Elective/Scheduled Medical Admissions]
- [Acute Rehabilitation Admissions]
- [Subacute Admissions]
- [Skilled Nursing Facility (SNF) Admissions]
- [Long-Term Acute Care Facility Admissions]
- [Admissions for Alcohol, Drug and/or Substance Abuse]
- [Mental Illness Admissions]

[TREATMENTS RELATED TO THE FOLLOWING SERVICES]

- [Transplants: BMT and Solid Organ]
- [Investigational or Experimental Services, Procedures or Devices]
- [Clinical Trials]
- [Implantable Cardioverter Defibrillators]
- [New Services and Technology]
- [Temporary Codes (T-codes)]

[SURGICAL PROCEDURES (INPATIENT OR OUTPATIENT SERVICES)]

- [Bariatric Surgery]
- [Cochlear Implant]
- [Infertility Procedures]
- [Orthognathic Surgery]
- [Pain Management Procedures]
- [Plastic, Reconstructive and/or Cosmetic Procedures]
- [Spinal Surgeries]
- [Total Joint Replacements]
- [Uvulopalatopharynogoplasty (UPPP)]
- [Vein Procedures]

[OUTPATIENT SERVICES/TREATMENT (OUTPATIENT, OFFICE, AND RELATED SERVICES)]

- [Capsule Endoscopy]
- [Cardiac Rehabilitation]
- [Dental Anesthesia]
- [Durable Medical Equipment (DME)]
- [External Counterpulsation (EECP)]
- [Home Health Care Visits]
- [Hyperbaric Oxygen Therapy]
- [Injectable and Home Infusions]
- [Liquid Oxygen]
- [Orthotics]
- [Pain Management Programs]
- [Prosthetics]
- [Pulmonary Rehabilitation]
- [Sleep Studies]
- [Therapies: PT, OT, ST]

[RADIOLOGY SERVICES]

- [CT: Head, Abdomen]
- [MRI: Brain, Joint, Spine]
- [PET Scan]
- [Proton Beam Therapy]
- [SPECT Scan: Heart, Brain, Tumor Imaging and Localization of Inflammatory Process]

[The Company will review submitted medical information to determine the Medical Necessity and appropriateness of the service, as defined by the Policy. Review determinations are generally made within [three (3) business days] of receipt of complete medical information. Services deemed not Medically Necessary will not be eligible for benefits under the Policy.]]

II. INPATIENT BENEFITS

Please refer to your Schedule of Benefits for further information including, but not limited to, any applicable [Copayments], [Coinsurance], [Deductibles], and limitations for all provisions listed in Section One.

1. [Alcohol, Drug or Other Substance Abuse Treatment and Detoxification. Inpatient treatment for Alcohol, Drug or Other Substance Abuse is covered. Detoxification is the medical treatment of withdrawal from alcohol, drug or other substance addiction. Treatment in an acute care setting is covered for the acute stage of alcohol, drug or other substance abuse withdrawal when medical complications occur or are highly probable.

   [For Smoking cessation, please see Section III. Outpatient Benefits]]

2. Blood and Blood Products. Blood and blood products are covered. Autologous (self-donated), donor-directed, and donor-designated blood processing costs are limited to blood collected for a scheduled procedure.

3. [Clinical Trials. Clinical Trials, subject to the Company's review and approval based on the criteria below, are covered. If You join a Clinical Trial, the Company will only pay the Coinsurance or Deductible as outlined for Inpatient Benefits in the Schedule of Benefits.

   An approved Clinical Trial shall either: (1) involve a Drug that is exempt under federal regulations from a new Drug application; or (2) is approved by one of the following:

   - One of the National Institutes of Health
   - The federal Food and Drug Administration, in the form of an Investigational new Drug application
   - The United States Department of Defense
   - The United States Veterans' Administration

   A Clinical Trial with endpoints defined exclusively to test toxicity is not a Covered Expense.]

4. [Foreign Country Travel Benefit (Medically Necessary Emergency Services). Medically Necessary Emergency Hospital, Physician and medical care services received in a foreign country are covered if the Covered Person lost entitlement to Medicare solely because of a temporary absence from the United States. Benefits will be:

   - Limited to charges covered if care had been provided in the United States;
   - Limited to treatment that began during the Covered Person's first [six (6) months] outside the United States;
   - Limited to Covered Persons whose primary residence is in the United States; and
   - Limited to those charges for which the Covered Person is required to pay.]

5. Hospice Services. Hospice services are covered for Covered Persons with a terminal illness, defined as a medical condition resulting in a prognosis of life expectancy of six (6) months or less, if the Sickness follows its natural course. Hospice services are provided as determined by the plan of care developed by the Covered Person's interdisciplinary team, which includes, but is not limited to, the Covered Person, the Physician, a registered nurse and a social worker.

Hospice services are provided in an appropriately licensed Medicare-approved Hospice Facility or program when the Covered Person's interdisciplinary team has determined that the Covered Person's care cannot be managed at home because of acute complications or the temporary absence of a capable primary caregiver, or when it is necessary to relieve the family members or other persons caring for the Covered Person ("Respite Care"). Respite Care is limited to an occasional basis and to no more than five (5) consecutive days at a time.

Hospice services include: Skilled Nursing Services, certified Home Health Aide Services and homemaker services under the supervision of a qualified registered nurse; bereavement services; social services/counseling services; medical direction; volunteer services; pharmaceuticals, medical equipment and supplies that are reasonable and necessary for the palliation and management of the terminal illness and related conditions; and physical and occupational therapy and speech-language pathology services for purposes of symptom control, or to enable the Covered Person to maintain activities of daily living and basic functional skills.

6. Hospital/Acute Care Services. Inpatient Hospital Services authorized by the Company are covered, including but not limited to: semi-private room, nursing and other licensed health professionals, intensive care, operating room, recovery room, laboratory and professional charges by the Hospital-based pathologist, radiologist, or anesthesiologist, emergency room Physician, emergency room and other miscellaneous Hospital charges for care and treatment.

7. [Maternity Care. Prenatal and Maternity care services are covered, including labor, delivery and recovery room charges, delivery by cesarean section, treatment of miscarriage and Complications of Pregnancy or childbirth.

   - Alternative birthing center services are covered when the Facility is connected with or to a Hospital Facility.
   - [Licensed/Certified] Nurse midwife services are covered.
   - Elective home deliveries are not covered.

   A minimum 48-hour Inpatient stay for normal vaginal delivery and a minimum 96-hour Inpatient stay following delivery by cesarean section are covered. Coverage for Inpatient Hospital care may be for a time period less than the minimum hours if the decision for an earlier discharge of the mother and newborn is made by the treating Physician in consultation with the mother. [In addition, if the mother and newborn are discharged prior to the 48-hour or 96-hour minimum time periods, a post-discharge follow-up visit for the mother and newborn will be provided within 48 hours of discharge, when prescribed by the treating Physician.]

8. Mastectomy, Breast Reconstruction after Mastectomy and Complications from Mastectomy. Medically Necessary Mastectomy and lymph node dissection are covered, including prosthetic devices and/or Reconstructive Surgery to restore and achieve symmetry for the Covered Person incident to the mastectomy. The length of a Hospital stay is determined by the attending Physician and surgeon in consultation with the Covered Person, consistent with sound clinical principles and processes. Coverage includes any initial and subsequent Reconstructive Surgeries or prosthetic devices for the diseased breast on which the mastectomy was performed. Coverage is provided for surgery and reconstruction of the other breast if, in the opinion of the attending surgeon, this surgery is necessary to achieve

symmetrical appearance. Medical treatment for any complications from a mastectomy, including lymphedema, is covered.

A 48-hour minimum Inpatient stay in connection with a mastectomy is covered. Coverage for an Inpatient stay may be for a time period less than the minimum hours if the decision for the earlier discharge is made by an attending Physician in consultation with the Covered Person.

9. Mental Health Care. Inpatient psychiatric services in a Medicare-certified Facility are covered.

Services must be for "active treatment," which is defined by the following criteria:

- Services are provided under an individualized treatment or diagnostic plan;
- Services are reasonably expected to improve the Covered Person's condition or for the purpose of diagnosis; and
- Services must be supervised and evaluated by a Physician.

10. [Newborn Care. Postnatal Hospital Services and special care nursery services are covered, including elective circumcision when performed in the Hospital before discharge or within six (6) months of birth if delayed for medical reasons.]

11. Organ Transplant and Transplant Services. Non-Experimental and Non-Investigational organ transplants and transplant services are covered when the recipient is a Covered Person and the transplant is performed at a Medicare participating Facility. Food and housing is not covered.

Autologous and allogeneic bone marrow and stem cell transplants are covered. The testing of blood relatives to determine the compatibility of bone marrow and stem cells is limited to immediate blood relatives who are sisters, brothers, parents and natural children. The testing for compatible unrelated donors, and costs for computerized national and international searches for unrelated allogeneic bone marrow or stem cell donors conducted through a registry, are covered when the Covered Person is the intended recipient.

12. Physician Services. Services from Physicians, including specialists and other licensed health professionals are covered while the Covered Person is Hospitalized as an Inpatient.

13. Rehabilitation Services. Rehabilitation Services that must be provided in an Inpatient rehabilitation Facility are covered. Rehabilitation Services are the individual or combined and coordinated use of medical, physical, occupational and speech-language pathology services for training and retraining individuals disabled by Sickness or Injury. A rehabilitation Facility provides comprehensive Rehabilitation Services under the supervision of a Physician to Inpatients with physical disabilities.

14. Reconstructive Surgery. Reconstructive Surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or Sickness is covered. The primary purpose of Reconstructive Surgery is to correct abnormal structures of the body to improve function. Reconstructive procedures require Preauthorization by the Company.

15. Skilled Nursing Services/Subacute and Transitional Care. Medically Necessary Inpatient Skilled Nursing Services in a Medicare-certified Skilled Nursing Facility are covered. Skilled

Nursing Services are covered if the insured requires Skilled Nursing Services or skilled Rehabilitation Services on a daily basis and these skilled services can be provided only on an Inpatient basis in a Skilled Nursing Facility. Inpatient stays solely to provide Custodial Care are not covered.

Covered Services include, but are not limited to the following: Semi-private room (private room if Medically Necessary); meals, including special diets; regular nursing services; physical therapy, occupational therapy, and speech-language pathology services; Drugs (this includes substances that are naturally present in the body, such as blood clotting factors); blood; medical and surgical supplies; laboratory tests; X-rays and other radiology services; use of appliances such as wheelchairs; and Physician services.

III. OUTPATIENT BENEFITS

Please refer to your Schedule of Benefits for further information including, but not limited to, any applicable [Copayments], [Coinsurance], [Deductibles], and limitations for all provisions listed in Section One.

1. [Acupuncture [and Acupressure]. Acupuncture [and Acupressure] [is][are] covered when Medically Necessary and performed by a licensed acupuncturist.]

2. Alcohol, Drug or Other Substance Abuse Treatment and Detoxification. Outpatient treatment for Alcohol, Drug or Other Substance Abuse is covered. Detoxification is the medical treatment of withdrawal from alcohol, drug or other substance addiction. Treatment in an acute care setting is covered for the acute stage of alcohol, drug or other substance abuse withdrawal when medical complications occur or are highly probable.

   [Smoking cessation counseling sessions are covered for an enrollee with a disease aggravated by tobacco; performed by a health care professional within the scope of his or her licensure; up to [4-12] sessions [in a [12–24] month period]. Definition: A session is 10 minutes or more of face-to-face counseling by a health care professional within the scope of his or her licensure, e.g., social worker, psychologist, Physician Assistant, MD/DO, or Nurse Practitioner or Clinical Nurse Specialist.]

3. [Allergy Serum. Allergy serum, as well as needles, syringes, and other supplies for the administration of the serum are covered for the treatment of allergies.]

4. Ambulance. The use of an ambulance (land or air) is covered when the Covered Person, as a prudent layperson, reasonably believes that the medical or psychiatric condition requires services, and an ambulance transport is necessary to receive these services. Such coverage includes, but is not limited to, ambulance or ambulance transport services provided through the "911" emergency response system. Ambulance transportation is limited to the nearest available emergency Facility having the expertise to stabilize the Covered Person's Emergency Medical Condition. Use of an ambulance for non-Emergency Services is limited to inter-Facility transfers between two Hospitals, between a Hospital and a non-custodial Skilled Nursing Facility, or between a non-custodial Skilled Nursing Facility and dialysis or radiation therapy are covered when Medical Necessity criteria for an ambulance is met.

5. Blood and Blood Products. Blood and blood products are covered. Autologous (self-donated), donor-directed, and donor-designated blood processing costs are limited to blood collected for a scheduled procedure.

6. [Clinical Trials. If you join a Clinical Trial, the Company will only pay the Coinsurance or Deductible as outlined for Outpatient Benefits in the Schedule of Benefits.]

7. Dental Treatment Anesthesia. See "Oral Surgery and Dental Services" and "Oral Surgery and Dental Services: Dental Treatment Anesthesia" provisions below.

8. Diabetic Management and Treatment. Coverage includes Outpatient self-management training, education and medical nutrition therapy services. The diabetes Outpatient self-management training, education and medical nutrition therapy services covered under this benefit will be provided by appropriately licensed or registered health care professionals. These services must be provided under the direction of and be prescribed by a Provider acting within the scope of his or her licensure.

9. Diabetic Self-Management Items. Equipment and supplies for the management and treatment of diabetes are covered, based upon the medical needs of the Covered Person, including but not necessarily limited to: blood glucose monitors; blood glucose monitors designed to assist the visually impaired; strips; lancets and lancet puncture devices; insulin pumps and all related necessary supplies; ketone urine testing strips; podiatry services and devices to prevent or treat diabetes related complications.

10. Dialysis. Acute and chronic dialysis services and supplies are covered.

11. Drugs and Prescription Medication Covered by Medicare]

- [Outpatient Prescription Drugs. The following Outpatient Prescription Drugs are covered when approved by Medicare: Osteoporosis Drugs; Erythropoietin (Epogen) or Epoetin Alfa; Hemophilia Clotting Factors; Immunosuppresive Drugs; Oral Cancer Drugs; and Oral Anti-Nausea Drugs.

- [Infusion Therapy. Infusion therapy means the therapeutic use of Drugs or other substances, prepared or compounded, and administered by a Provider and given to a Covered Person through a needle or catheter. Services must be provided in the Covered Person's home or an institution that is not a Hospital or is not primarily engaged in providing skilled nursing or Rehabilitation Services. (For example, board and care, custodial care Facility and assisted living Facility) Infusion therapy is only covered as part of a treatment plan prescribed by a Physician.]

- [Outpatient Injectable Medications. Outpatient injectable medications include those Drugs or preparations that are not usually self-administered, and which are given by the Intramuscular or Subcutaneous route. Outpatient injectable medications [(except insulin)] are covered when administered as a customary component of a Physician's office visit and when not otherwise limited or excluded (e.g., [insulin,] certain immunizations, [infertility Drugs,] [birth control,] or off-label use of covered injectable medications).]

12. Durable Medical Equipment (Rental, Purchase or Repair). Durable Medical Equipment is covered when it is designed to assist in the treatment of an Injury or Sickness of the Covered Person, and the equipment is for use in the home. Durable Medical Equipment is medical equipment that can exist for a reasonable period of time without significant deterioration. Examples of covered Durable Medical Equipment include wheelchairs, Hospital beds and standard oxygen delivery systems. Replacements, repairs and adjustments to Durable Medical Equipment are limited to normal wear and tear or because of a significant change in

the Covered Person's physical condition.

13. Eye Exams. Some preventive eye tests and screenings are covered. Coverage includes a yearly eye exam for diabetic retinopathy, and a glaucoma screening every 12 months for people with diabetes or a family history of glaucoma, or for African Americans age 50 and older. Ocular photodynamic therapy with verteporfin, a treatment for patients with age-related macular degeneration, is also covered.

14. Eyewear. Eyewear and corrective lenses are covered following cataract surgery with an intraocular lens (IOL) and when the Covered Person is missing an intraocular lens without a replacement either after cataract surgery or naturally. If an IOL is placed, the Covered Person is entitled to one pair of frames and lenses after each cataract surgery. If the Covered Person does not have an IOL, then the Covered Person is covered for ongoing contacts and glasses through the prosthetic benefit.

15. [Foreign Country Travel Benefit (Medically Necessary [Emergency] Services). Medically Necessary [Emergency] Hospital, Physician and medical care services received in a foreign country are covered if the Covered Person lost entitlement to Medicare solely because of a temporary absence from the United States. Benefits will be: (1) limited to charges covered if care had been provided in the United States; (2) limited to treatment that began during the Covered Person's first [six (6) months] outside the United States; (3) limited to Covered Persons whose primary residence is in the United States; and (4) limited to those charges for which the Covered Person is required to pay.]

16. Hearing Exams. Audiology services performed to determine the need for, or the appropriate type of, hearing aid are covered.

17. Home Health Care. Covered Home Health Services for those who qualify may include: part-time or intermittent skilled nursing and Home Health Aide Services; physical and occupational therapy and speech pathology services; medical social services; medical supplies and Durable Medical Equipment (such as wheelchairs, Hospital beds, oxygen, walkers).

    When You qualify for coverage of Home Health Services, the Plan covers either part-time or intermittent skilled nursing and Home Health Aide Services in accordance with Medicare guidelines. Part-time or intermittent means any number of days per week up to [16-48 hours per week] of skilled nursing and Home Health Aide Services combined for less than [4-12 hours per day], based upon the reasonable need for such care. The Plan may cover, subject to review on a case-by-case basis depending on the need for such care, [16-35] or fewer hours per week of skilled nursing and Home Health Aide Services combined for less than [4-12] hours per day.

    A homebound Covered Person has restricted ability, due to an illness or Injury, to leave home without assistance of another person or aid of a supportive device (such as crutches, a cane, a wheelchair or a walker), or if leaving the home is contraindicated. You do not have to be bedridden in order to be considered confined to the home. However, Your condition should be such that there exists a normal inability to leave the home and, consequently, leaving the home would require a considerable and taxing effort. If You leave the home, You may be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or to receive medical treatment, including regular absences for the purpose of participating in therapeutic, psychosocial or medical treatment in an adult day-care program that is licensed or certified by the state, or to attend religious services.

Home health services do not include the costs of housekeepers, food service arrangements, or full-time nursing care at home.

18. Hospice Services. Hospice Services are covered for Covered Persons with a terminal illness, defined as a medical condition resulting in a prognosis of life expectancy of six (6) months or less, if the Sickness follows its natural course. Hospice services are provided pursuant to the plan of care developed by the Covered Person's interdisciplinary team, which includes, but is not limited to, the Covered Person, the Covered Person's Physician, a registered nurse, a social worker and a spiritual caregiver.

    Covered Hospice services are available in the home on a 24-hour basis during periods of crisis, when a Covered Person requires continuous care to achieve palliation or management of acute medical symptoms.

19. In Vitro Fertilization. Coverage is provided for in vitro fertilization performed at a medical facility certified by the Arkansas Department of Health which conforms to the American College of Obstetricians and Gynecologists' guidelines for in vitro fertilization clinics, or the American Fertility Society's minimal standards for programs of in vitro fertilization. Coverage is not provided for procedures involving sperm or egg donors. Benefits are limited to a lifetime maximum of fifteen thousand ($15,000) dollars.

20. Laboratory and Diagnostic Services. Medically Necessary diagnostic and therapeutic laboratory services and other Medically Necessary diagnostic services are covered.

21. [Maternity Care, Tests and Procedures. Physician visits, laboratory services and radiology services are covered for prenatal and postpartum Maternity care.

    Nurse midwife services are covered by midwives practicing within the scope of their license.

    Genetic testing and counseling are covered as part of an amniocentesis or chorionic villus sampling procedure.]

22. Medical Supplies and Materials. Medical supplies and materials necessary to treat a Sickness or Injury are covered when used or furnished while the Covered Person is being treated in the Provider's office or in the home by a licensed health care professional, or used in conjunction with Durable Medical Equipment for proper functioning of the Durable Medical Equipment.

23. Mental Health Care. Outpatient psychiatric services must meet the following criteria to be covered:

    - Services incident to a Physician's service;
    - Services for the purpose of diagnostic study or would reasonably be expected to improve the Covered Person's condition;
    - The treatment must be designed to reduce or control the Covered Person's psychiatric symptoms so as to prevent relapse or Hospitalization and improve or maintain the patient's level of functioning;
    - Services must be prescribed by a Physician and provided under an individualized written plan of treatment established by a Physician;
    - Services must be supervised and evaluated by a Physician to determine the extent to which treatment goals are being realized;

- Partial Hospitalization services when the Covered Person is discharged from an Inpatient Hospital treatment program, and the partial Hospitalization program is in lieu of continued Inpatient treatment;
- Partial Hospitalization services for Covered Persons who, in the absence of partial Hospitalization, would be at reasonable risk of requiring Hospitalization.

24. [Neuromuscular Skeletal Disorder Services. Treatment by means of manual manipulation of the spine to correct a subluxation, provided by a licensed chiropractor (DC), doctor of medicine (MD) or doctor of osteopathy (DO) are covered]

25. Oral Surgery and Dental Services. Emergency Services for stabilization of an acute Injury to sound natural teeth, the jawbone or surrounding structures are covered.

Other covered Oral Surgery and Dental Services include:

- Biopsy and excision of cysts or tumors of the jaw, treatment of ~~malignant~~ neoplastic disease, treatment of temporomandibular joint ("TMJ") syndrome, and treatment of craniomandibular disorder;
- Preventive fluoride treatment prior to an aggressive chemotherapeutic or radiation therapy protocol; and
- Tooth extraction prior to a major organ transplant or radiation therapy to the head or neck.

26. Oral Surgery and Dental Services: Dental Treatment Anesthesia. Anesthesia and associated Facility charges for dental procedures provided in a Hospital or Outpatient surgery center are covered when the Covered Person's clinical status or underlying medical condition requires use of an Outpatient surgery center or Inpatient setting for the provision of the anesthesia for a dental procedure(s) that ordinarily would not require anesthesia in a Hospital or Outpatient surgery center setting.

27. Outpatient Surgery. Short stay, same day or other similar Outpatient surgery services (of less than twenty-four (24) hours) are covered when provided as a substitute for Inpatient care at a Hospital or licensed free-standing Outpatient surgical center.

28. Periodic Health Screenings [(age 19 and over)]. Periodic Health Screenings are covered and shall not exceed the limits shown below. This benefit includes the following health screenings:

a. Diagnostic Hearing Screening. Hearing examination to evaluate hearing loss. Further diagnostic testing by an Audiologist, including hearing and balance assessment services, when the Covered Person's Physician orders the testing as part of a diagnostic evaluation, or to determine the appropriate medical or surgical treatment of a hearing deficit or related medical problem. These services are not covered when the diagnostic information required to determine the appropriate medical or surgical treatment is already known to the Physician, or the diagnostic services are performed only to determine the need for the appropriate type of hearing aid.

b. Immunizations for adults are covered consistent with the most current recommendations of the Centers for Disease Control and Prevention (CDC) for routine adult immunizations as advised by the Advisory Committee on Immunization Practices.

c. Diagnostic laboratory services (age and gender appropriate) in conjunction with an office visit.

d. Breast and Pelvic Cancer Screening and Diagnosis. Services for the screening and diagnosis of breast cancer, including a clinical breast exam and a Pelvic examination with Pap Smear once every twenty-four (24) months. If the Covered Person is at high risk for cervical or vaginal cancer, or if the Covered Person is of childbearing age and has had an abnormal Pap Test, this test is covered once every twelve (12) months. Mammography for screening or diagnostic purposes is covered as follows:

- A mammogram for women age 40 and over every twelve (12) months; and
- One baseline mammogram between the ages of 35 and 39.

e. Colorectal Cancer Screening includes an examination for Covered Persons age 50 and over, and who have an average risk of developing colon cancer as determined by a Physician. This screening may include the following:

- A fecal occult blood test performed once every twelve (12) months;
- A flexible sigmoidoscopy performed every five (5) years or a colonoscopy for initial screening only and performed every ten (10) years. (If additional therapeutic or surgical services are required during the screening as a result of screening findings, the Outpatient surgery Coinsurance and the Deductible will apply.);
- A colonoscopy performed once every twenty-four (24) months, if you are at high risk for colon cancer. If you are not at high risk for colon cancer, once every ten (10) years, but not within forty-eight (48) months of a screening sigmoidoscopy; and
- A barium enema can be performed instead of a flexible sigmoidoscopy or colonoscopy.

f. Detection of Osteoporosis using bone mass measurement used for the detection of low bone mass and for the determination of the Covered Person's risk of osteoporosis and fractures associated with osteoporosis. Osteoporosis detection services are Covered Services when provided to the following qualified Covered Persons:

- Postmenopausal women who are not receiving estrogen replacement therapy;
- Individuals with vertebral abnormalities, primary hyperparathyroidism, or a history of bone fractures;
- Individuals who are receiving long-term glucocorticoid therapy; or
- Individuals who are being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

g. Bone mass measurements if the following conditions are met:

- The test must be ordered by a doctor or qualified practitioner who is treating

You;

- Every two (2) years or more frequently if Medically Necessary; and
- One or more of the following conditions are met: women who are being treated for low estrogen levels and are at clinical risk for osteoporosis, based on their medical history and other findings; men and women on prednisone or steroid-type Drugs or who are planning to begin such treatment; men and women diagnosed with primary hyperparathyroidism; men and women being treated with a Drug for osteoporosis, to determine if the therapy is working.

h. Diagnostic laboratory services are limited to the following tests (as defined in Current Procedural Terminology (CPT) from the American Medical Association): complete blood count (CBC), urinalysis, thyroid stimulating hormone (TSH), prothrombin time/international normalized ratio (PT/INR), partial thromboplastin time (PTT), and organ or disease oriented panels. Components of the above tests are also covered if ordered individually.

i. Standard X-Rays. Standard X-rays are covered for the diagnosis of a Sickness or Injury, or to screen for certain defined diseases. Standard X-rays are defined to include conventional plain film X-rays, oral and rectal contrast gastrointestinal studies (such as upper GIs, barium enemas, and oral cholecystograms), mammograms, obstetrical ultrasounds, and bone mineral density studies (including ultrasounds and DEXA scans).

j. Prostate Screening. Evaluations for the screening and diagnosis of prostate cancer are covered for men age 50 and older (coverage begins the day after the 50th birthday), once every twelve (12) months. This screening may include, but is not limited to, the following:

- Prostate-specific antigen testing
- Digital rectal examination

k. Glaucoma screening once every twelve (12) months for people at high risk for glaucoma. This includes people with diabetes, a family history of glaucoma, or African Americans who are age 50 and older.

l. Flu shot once a year in the fall or winter.

m. Pneumococcal pneumonia shot (vaccine).

n. Hepatitis B shot (vaccine) if there is medium to high risk for Hepatitis B.

o. A foot exam is covered every six (6) months. Coverage is for individuals with diabetic peripheral neuropathy and loss of protective sensations, as long as there are no other visits to a foot care professional for another reason.

29. Phenylketonuria ("PKU") Testing and Treatment. Testing for Phenylketonuria ("PKU") is covered to prevent the development of serious physical or mental disabilities, or to promote normal development or function as a consequence of PKU enzyme deficiency. PKU includes those formulas and special food products that are part of a diet prescribed by a Physician and managed by a health care professional in consultation with a Physician who

specializes in the treatment of metabolic disease. "PKU" includes galactosemia, organic acidemias, and disorders of amino acid metabolism.

30. Physician Office Visits. Services for the detection and treatment of an Injury or Sickness during or associated with a Physician's office visit are covered. Covered services may include:

- Antigens
- Breast and Pelvic Cancer Screening including Mammography screening
- Colorectal Cancer Screenings
- Detection of Osteoporosis
- Diabetes Self-Monitoring Training [Supplies]
- Immunizations
- Immunosuppressives
- Inhalation Solutions
- [Nutrition Therapy]
- Oral Chemotherapy
- [Outpatient Injectables (Home-based, Self Administered, Home Health)]
- [Pain Management]
- Pap Smear
- Pelvic Exam
- Prostate Cancer Screening
- [Periodic health evaluations for children (through age 18) including age appropriate immunizations, laboratory tests, height and weight evaluation, vision screening]
- [Smoking cessation counseling]

31. Podiatry Services. Services of a podiatrist for Medically Necessary treatment of injuries or diseases of the foot, such as hammer toe or bunion deformities and heel spurs are covered. A foot exam is covered every six (6) months for people with diabetic peripheral neuropathy and loss of protective sensations as long as there has been no other covered visit to a foot care professional for another reason between visits.

32. [Routine Podiatry Services. Medically Necessary podiatry, including but not limited to a routine exam is covered.]

33. Preventive Care Services. Preventive Care Services are limited to Periodic Health Screenings, as shown in this section, including: Physician, lab, radiology or other tests; preventive measures or related services considered Medically Necessary and appropriate for age and gender to determine a Covered Person's health status.

Benefits will be based on the actual charges made by the Provider up to one hundred percent (100%) of the Medicare-approved amount for each service, as if Medicare were to cover the service, as identified in the American Medical Association Current Procedural Terminology (AMA CPT) codes (where applicable or based on Usual and Customary

Charges). This benefit will not include payment for any procedure covered by Medicare.

34. Prosthetics and Corrective Appliances. Prosthetics are covered. Bionic and microprocessors covered only when approved by Medicare. Custom-made or custom-fitted corrective appliances are covered. Replacements, repairs and adjustments to corrective appliances and prosthetics are limited to normal wear and tear or because of a significant change in the Covered Person's physical condition.

35. Radiation Therapy. Services for radiation therapy are covered.

36. Reconstructive Surgery. Surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or Sickness is covered. The purpose of reconstructive surgery is to correct abnormal structures of the body to improve function.

37. Rehabilitation Services and Therapy. Covered Outpatient services include physical therapy, speech therapy and occupational therapy for the treatment of a Sickness or Injury, provided by a licensed health care professional or under the direct supervision of a licensed health care professional.

38. Specialized Footwear. Specialized footwear, including foot orthotics, custom-made or standard orthopedic shoes, is covered for a Covered Person with diabetic foot disease or when an orthopedic shoe is permanently attached to an orthopedic brace.

39. Specialized Scanning and Imaging Procedures. Specialized scanning and imaging procedures are covered for the diagnosis of a Sickness or Injury. Specialized procedures are defined to include those which, unless specifically classified as standard X-rays, are digitally-processed, or computer-generated, or which require contrast administered by injection or infusion. Examples of specialized scanning and imaging procedures include, but are not limited to, the following scanning and imaging procedures: CT, PET, SPECT, MRI, MRA, EKG, EEG, EMG and nuclear scans, angiograms (includes heart catheterization), arthrograms, and myelograms.

40. [Sterilization. Benefits include sterilization procedures including, but not limited to, tubal ligations and vasectomies.]

41. Urgent Care Services. Benefits include Covered Services from an Urgent Care Facility.

IV. EXCLUSIONS AND LIMITATIONS OF BENEFITS

The following treatments, services or supplies are either limited or not covered, as follows:

1. Any expense or service that is not determined by the Company to be a Medicare Eligible Expense is not covered, unless coverage for the expense or service is specifically provided by this Certificate or Rider to the Policy.

2. Any treatment, service or supply determined by the Company to not be Medically Necessary is not covered. Payment for these services will be the Covered Person's financial responsibility.

3. Any service or supply determined by Medicare to not be necessary for the treatment of an illness or Injury is not covered.

4. Services not specifically included in Section One: Your Medical Benefits, or any supplemental Benefit Rider purchased by the Covered Person's Employer, are not covered. Payment for these services will be the Covered Person's financial responsibility.

5. Services rendered prior to the Covered Person's Effective Date of enrollment or after the Effective Date of disenrollment are not covered.

6. The Company does not cover the services or costs associated with a service that is not a Covered Service under the Covered Person's Policy including, but not limited, to cosmetic surgery, [bariatric surgery], and Experimental and Investigational procedures. This means that the Company will not cover follow-up care or complications associated with or arising from a non-Covered Service when:

   a) The services or expenses are incurred in preparation for a non-Covered Service;

   b) The complications or services are associated with non-Covered Services provided by another health plan or insurance company even if the service was covered under the prior plan;

   c) The complications or services are associated with non-Covered Services the Covered Person paid for out-of-pocket (e.g., cosmetic surgery, [bariatric surgery], Experimental and Investigational procedures).

7. Active Military Duty. Services incurred as a result of active military duty are not covered.

8. [Acupuncture [and Acupressure]. Acupuncture [and Acupressure] [is][are] not covered.]

9. Air Conditioners, Air Purifiers and Other Environmental Equipment. Air conditioners, air purifiers and other environmental equipment are not covered.

10. Ambulance. Ambulance services are not covered if they are not Medically Necessary or if used as a convenience for the Covered Person or his or her family. Wheelchair transportation services (e.g., a specially designed van or taxi) and personal transportation costs such as gasoline costs for a private vehicle or taxi fare are also not covered.

11. Bariatric Surgical Procedures. Bariatric surgical procedures are not covered.

12. Behavior Modification and Non-Crisis Mental Health Counseling and Treatment. Behavior modification and non-crisis mental health counseling and treatment are not covered. Examples include, but are not limited to, art therapy, music therapy and play therapy.

13. Blood and Blood Products. The costs of:

- Transportation and processing for autologous, donor-directed or donor-designated blood are not covered in excess of the cost of a unit of blood from a recognized blood bank organization.
- A platelet derived wound-healing formula such as Procuren or other similar blood products used in the repair of chronic, non-healing, cutaneous ulcers or wounds are not covered.
- Blood charges incurred by Covered Persons for services/supplies in conjunction with donating blood for another individual are not covered.
- Blood charges associated with non-covered procedures are not covered.

14. Bone Marrow and Stem Cell Transplants. Autologous or allogeneic bone marrow or stem cell transplants are not covered when they are Experimental or Investigational unless required by an external, independent review panel. Unrelated donor computer searches for Covered Persons who require a bone marrow or stem cell transplant are limited to the donor maximum for the Covered Person's transplant benefit.

15. [Complementary and Alternative Medicine. Complementary and alternative medicine are not covered.]

16. Cosmetic Services and Surgery. Cosmetic services and cosmetic surgery are not covered. Cosmetic services and cosmetic surgery are services performed to alter or reshape normal structures of the body in order to improve appearance. Drugs, devices and procedures related to cosmetic services or cosmetic surgery are not covered. Surgeries or services that would ordinarily be classified as cosmetic will not be reclassified as reconstructive, based on a Covered Person's dissatisfaction with his/her appearance, as influenced by that Covered Person's underlying psychological makeup or psychiatric condition.

17. Custodial Care. Custodial Care is not covered except for those services provided by an appropriately licensed Hospice agency or appropriately licensed Hospice Facility incident to a Covered Person's terminal illness as described in the explanation of Hospice Services in the Medical Benefits section of this Certificate.

18. Dental Care, Dental Services, Dental Appliances and Orthodontics. Except as otherwise provided under the Outpatient benefit captioned "Oral Surgery and Dental Services," dental care, dental appliances and orthodontics are not covered. Dental Care refers to all services required for prevention and treatment of diseases and disorders of the teeth, including, but not limited to: oral exams, X-rays, routine fluoride treatment, plaque removal, tooth decay, routine tooth extraction, dental embryonal tissue disorders, periodontal disease, crowns, fillings, dental implants, caps, dentures, braces, and orthodontic procedures. [Dental splints, dental prosthesis or any dental treatment for the teeth, gums or jaw, or dental treatment related to temporomandibular joint syndrome (TMJ), are not covered unless provided by a supplemental Benefit Rider.]

19. Dental Treatment Anesthesia. Dental treatment anesthesia provided or administered in a dentist's office is not covered unless provided by a supplemental Benefit Rider.

20. Diagnostic Admissions. Services in connection with a Hospital stay primarily for diagnostic tests which could have been performed on an Outpatient basis are not covered.

21. Disabilities Connected to Military Services. Treatment in a government Facility for a Sickness or Injury connected to military service that the Covered Person is legally entitled to receive through a federal governmental agency, and to which the Covered Person has reasonable access, is not covered.

22. Drugs and Prescription Medication (Outpatient). Outpatient Drugs and prescription medications are not covered unless provided by a supplemental Benefit Rider. Refer to benefits "Injectable Drugs" and "Infusion Therapy" in the Drugs and Prescription Medication provision of Outpatient Benefits for benefit coverage. Pen devices for the delivery of medication are not covered.

23. Durable Medical Equipment. Replacement of lost or stolen Durable Medical Equipment is not covered. The following equipment and accessories are not covered: non-Medically Necessary optional attachments and modifications to Durable Medical Equipment for the comfort or convenience of the Covered Person; accessories for portability or travel; a second piece of equipment with or without additional accessories that is for the same or similar medical purpose as existing equipment; home and/or vehicle modifications to accommodate the Covered Person's physical condition.

24. Educational Services for Developmental Delays and Learning Disabilities. Educational services to treat developmental delays or learning disabilities are not covered. A Learning Disability is a condition where there is a meaningful difference between a child's current academic level of function and the level that would be expected for a child of that age. Educational services include, but are not limited to, language and speech training, reading, psychological and visual integration training.

25. Elective Enhancements. Elective or voluntary enhancement services, procedures, treatments, supplies and medications, including but not limited to, services related to weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance are not covered.

26. Exercise Equipment and Services. Exercise equipment or any charges for activities, instructions or facilities normally intended or used for developing or maintaining physical fitness are not covered. This includes, but is not limited to, charges for physical fitness instructors, health clubs, gyms, home exercise equipment or swimming pools, even if ordered by a health care professional.

27. Experimental and/or Investigational Procedures, Items and Treatments. Experimental and/or Investigational Procedures, items and treatments are not covered unless otherwise required by federal or state law. Unless otherwise required by federal or state law, decisions as to whether a particular treatment is Experimental or Investigational, and therefore not a covered benefit, are determined by a Company Medical Director, or his or her designee. Procedures, studies, tests, drugs or equipment will be considered Experimental and/or Investigational if any of the following criteria/guidelines is met:

- It cannot lawfully be marketed without the approval of the Food and Drug Administration (FDA) and such approval has not been granted at the time of its use or proposed use.
- It is a subject of a current investigation of new drug or new device (IND) application on file with the FDA.
- It is the subject of an ongoing clinical trial (Phase I, II or the research arm of Phase III) as defined in regulations and other official publications issued by the FDA and Department of Health and Human Services (DHHS).
- It is being provided pursuant to a written protocol that describes among its objectives the determination of safety, efficacy, toxicity, maximum tolerated dose or effectiveness in comparison to conventional treatments.
- It has not been proven to have shown a demonstrable benefit for diagnosing or treating a particular illness or disease for which its use has been proposed in prevailing peer-reviewed literature.
- It is being delivered or should be delivered subject to approval and supervision of an institutional review board (IRB) as required and defined by federal regulations or other official actions (especially those of the FDA or DHHS).
- Other facilities studying substantially the same drug, device, medical treatment or procedures refer to it as experimental or as a research project, a study, an invention, a test, a trial or other words of similar effect.
- The predominant opinion among experts as expressed in published, authoritative medical literature is that usage should be confined to research settings.
- It is not Experimental or Investigational itself pursuant to the above criteria, but would not be Medically Necessary except for its use in conjunction with a drug, device or treatment that is Experimental or Investigational (e.g., lab tests or imaging ordered to evaluate the effectiveness of an Experimental therapy).

The sources of information to be relied upon by the Company in determining whether a particular treatment is Experimental or Investigational, and therefore not a covered benefit under this plan include, but are not limited to, the following:

- The Covered Person's medical records;
- The protocol(s) pursuant to which the drug, device, treatment or procedure is to be delivered;
- Any informed consent document the Covered Person, or his or her representative, has executed or will be asked to execute, in order to receive the drug, device, treatment or procedure;
- The published authoritative medical and scientific literature regarding the drug, device, treatment, or procedure;
- Expert medical opinion;
- Opinions of other agencies or review organizations, e.g., ECRI Health Technology Assessment Information Services, HAYES New Technology Summaries or MCMC Medical Ombudsman;
- Regulations and other official actions and publications issued by agencies such as

the FDA, DHHS and Agency for Health Care Policy and Research ("AHCPR").

[A Covered Person with a life threatening or seriously debilitating condition may be entitled to an expedited external, independent review of the Company's coverage determination regarding Experimental or Investigational therapies.]

28. Eyewear and Corrective Refractive Procedures. Corrective lenses and frames, contact lenses and contact lens fitting and measurements are not covered unless provided by an attached supplemental Benefit Rider. Surgical and laser procedures to correct or improve refractive error are not covered unless provided by an attached supplemental Benefit Rider. This exclusion does not apply following cataract surgery with an intraocular lens (IOL) and when the Covered Person is missing an intraocular lens without a replacement either after cataract surgery or naturally. If an IOL is placed, the Covered Person is entitled to one pair of frames and lenses after each cataract surgery. If the Covered Person does not have an IOL, then the Covered Person is covered for ongoing contacts and glasses through the prosthetic benefit.

29. Family Planning. Family planning is not covered. Family planning is defined as services and supplies related to a surgical or medical voluntary termination of pregnancy. This exclusion does not apply to therapeutic abortions where the mother's life is in danger or the fetus is not viable.

30. Foot Care. Routine foot care, including, but not limited to, removal or reduction of corns and calluses, and clipping of toenails, is not covered.

31. Foot Orthotics/Footwear. Specialized footwear, including foot orthotics and custom-made or standard orthopedic shoes, is not covered. However, specialized footwear may be covered for Covered Persons with diabetic foot disease or when an orthopedic shoe is permanently attached to an orthopedic brace. (Refer to the "Prosthetics and Corrective Appliances" benefit in Section One: Your Medical Benefits.)

32. Foreign Country Travel. Any charges for services incurred while in a foreign country are not covered unless specified in the Schedule of Benefits.

33. Genetic Testing and Counseling. Genetic testing and counseling are excluded for all of the following:

- Non-Covered Person.
- Solely to determine the gender of a fetus.
- Non-medical reasons (e.g., court-ordered tests, work-related tests, paternity tests).
- Screening of newborns, children or adolescents to determine carrier status for inheritable disorders when there would not be an immediate medical benefit or when results would not be used to initiate medical interventions during childhood.
- Covered Persons who have no clinical evidence or family history of a genetic abnormality.
- Covered Persons who do not meet the Company's Medical Necessity criteria for genetic testing and counseling.

34. Government Services and Treatment. Any services that the Covered Person receives from a local, state or federal governmental agency are not covered.

35. Hearing Aids and Hearing Devices. Hearing aids and non-implantable hearing devices are not covered unless provided by a supplemental Benefit Rider. Hearing aid supplies are not covered.

36. Immunizations. Travel and/or required work-related immunizations are not covered.

37. Implants. The following implants and services are not covered:

- Removal and/or replacement of breast implants for non-medical reasons.
- Replacement of breast prosthesis and the prosthesis itself following cosmetic breast augmentation mammoplasty.

38. Infertility Services. Infertility services are not covered, except as provided in the Outpatient Benefits section.

39. Institutional Services and Supplies. Except for Skilled Nursing Services provided in a Skilled Nursing Facility, any services or supplies furnished by a Facility that is primarily a place of rest, a place for the aged, a nursing home or any similar institution, regardless of affiliation or denomination, are not covered.

40. Maternity Services and Education. Educational courses on lactation, childcare and/or prepared childbirth classes are not covered.

41. Neuromuscular Skeletal Disorder Services. Services are limited to Neuromuscular Skeletal Disorder Services as described in the Outpatient Benefits section of this Certificate and as provided by a supplemental Benefit Rider, if any.

42. Nurse Midwife Services. Elective home deliveries are not covered.

43. [Nursing, Private Duty. Private Duty Nursing is not covered.]

44. Nutritional Supplements or Formulas. Formulas, food, vitamins, herbs and dietary supplements are not covered[,except as described under the Outpatient description of "Phenylketonuria (PKU) Testing and Treatment."]

45. Off-Label Drug Use. Off-Label Drug Use, which means the use of a Drug for a purpose that is different from the use for which the Drug has been approved by the FDA, including off-label self-injectable Drugs or infusion therapy, is not covered except as follows:

    If a Drug is prescribed for Off-Label Drug Use, the Drug and its administration will be covered if such Drug is recognized for treatment of such indication in one of the standard reference compendia, or in the medical literature as recommended by current American Medical Association policies.

    There is no coverage if the FDA has determined the use to be contraindicated for the treatment of the particular indication for which the Drug has been prescribed, for experimental or investigational Drugs not approved for any indication by the FDA, or for any Drug not included on the Drug formulary or list of covered Drugs specified in this Certificate.

    Nothing in this provision shall prohibit the Company from use of a formulary, [Copayment] [Coinsurance].

46. Organ Donor Evaluation and Services. Medical and Hospital Services, as well as other costs of a donor or prospective donor, are only covered when the recipient is a Covered Person. Covered Services for living donors are limited to transplant-related clinical services once a donor is identified. The testing of blood relatives to determine compatibility for donating organs is limited to sisters, brothers, parents and natural children.

47. Physical or Psychological Examinations. Physical or psychological examinations for court hearings, travel, premarital, pre-adoption, employment or other non-preventive health reasons are not covered.

48. Private Rooms and Comfort Items. Personal or comfort items, and non-Medically Necessary private rooms during Inpatient Hospitalization, are not covered.

49. Reconstructive Surgery. Reconstructive surgeries are not covered when there is another more appropriate surgical procedure that has been offered to the Covered Person, and the surgery does not restore body function.

50. Recreational, Lifestyle, Educational or Hypnotic Therapy. Recreational, lifestyle, educational or hypnotic therapy, and any related diagnostic testing, are not covered except for diabetic self-management training.

51. Rehabilitation Services and Therapy. Rehabilitation services and therapy are either limited or not covered, as follows:

- Speech, occupational or physical therapy are not covered when medical documentation does not support the Medical Necessity because of the Covered Person's inability to progress toward the treatment plan goals or when a Covered Person has already met the treatment goals.
- Speech therapy is limited to Medically Necessary therapy to treat speech disorders caused by a defined Sickness, Injury or surgery (for example, cleft palate repair). Speech therapy for stuttering, lisping or delayed speech is not covered.
- Cognitive Rehabilitation Therapy is limited to initial neuropsychological testing by a treating Physician or licensed Provider and the Medically Necessary treatment of functional deficits as a result of traumatic brain injury or cerebral vascular insult. This benefit is subject to the maximum benefit for Outpatient rehabilitation and applicable Coinsurance and Deductibles apply.
- Exercise programs are only covered when they require the direct supervision of a licensed physical therapist and are part of a Physician's treatment plan.
- Aquatic/pool therapy is not covered unless conducted by a licensed physical therapist and part of a Physician's treatment plan.
- Massage therapy is not covered.
- Activities that are motivational in nature or that are primarily recreational, social or for general fitness, are not covered.
- Cognitive behavioral therapy is not covered.
- Developmental and neuroeducational testing beyond initial diagnosis is not covered.
- Developmental and neuroeducational treatment is not covered.
- Hypnotherapy is not covered.

- Psychological testing is not covered.
- Vocational rehabilitation is not covered.

[Rehabilitation Services and therapies for the following conditions are not covered:

- Learning Disability.
- Mental Retardation and Related Conditions.]

52. Respite Care. Respite Care is not covered, unless part of an authorized Hospice plan and is necessary to relieve the primary caregiver in a Covered Person's residence. Respite Care is covered only on an occasional basis, not to exceed five (5) consecutive days at a time. R

53. Reversal of Sterilization Procedures. Reversal of sterilization procedures; sex change operations; conception by artificial means, which includes, but is not limited to, insemination procedures, in-vitro fertilization, zygote intrafallopian transfers and gamete intrafallopian transfers; and non-prescription contraceptive supplies and devices are not covered.

54. Self-Injectable Medications. Self-injectable medications are defined as those Drugs that are either generally self-administered by Intramuscular injection at a frequency of one or more times per week, or which are generally self-administered by the Subcutaneous route.] Self-injectable medications are not covered except for the following:

- Blood clotting factors.
- Drugs used in immunosuppressive therapy.
- Erythropoietin for dialysis patients.

55. Services Provided at No Charge to the Covered Person. Services and supplies that are provided free of charge if the Covered Person did not have coverage under this Policy or for which the Covered Person will not be held financially responsible are not covered, unless the Company has agreed to payment arrangements prior to the provision of the services or supplies to the Covered Person.

56. Services While Incarcerated or Confined. Services required for Injuries or Sicknesses experienced while under arrest, detained, imprisoned, incarcerated or confined pursuant to federal, state or local law are not covered. However, the Company will reimburse Covered Persons their out-of-pocket expenses for services received while confined/incarcerated or, if a juvenile, while detained in any facility, if the services were provided or authorized by the Company in accordance with the terms of this Certificate.

57. Sex Transformations. Procedures, services, medications and supplies related to sex transformations are not covered.

58. Sexual Dysfunction or Inadequacy Medications. Sexual dysfunction or inadequacy medications/drugs, procedures, services and supplies, including penile implants/prosthesis except testosterone injections for the documented low testosterone levels are not covered.

59. Skin Reduction Surgery. Surgical removal of excessive skin following massive weight loss associated with bariatric surgery or other weight loss programs is not covered.

60. Surrogacy. Infertility and Maternity services for non-Covered Persons are not covered.

61. Telehealth. Telehealth services are not covered [except as provided by state law] [unless determined to be Medically Necessary by the Company Medical Director].

62. Transplant Services. Transplant services are not covered when the transplant is not performed at a Medicare-certified Transplant Center. Non-human organs and artificial hearts are not covered.

63. Transportation. Transportation is not a covered benefit except as covered under the Ambulance and Organ Transplant Services benefits in this Certificate.

64. Veterans' Administration Services. Veterans' Administration (VA) services are not covered.

65. Vision Training. Vision therapy rehabilitation and ocular training programs (orthoptics) are not covered.

66. Weight Alteration Programs. Weight loss or weight gain programs are not covered.

67. Workers' Compensation. Services payable under Workers' Compensation are not covered.

68. War. Services incurred as a result of declared or undeclared war are not covered.

SECTION TWO

Payment Responsibility

- Claims Policies and Procedures
- Coordination of Benefits

This section explains Claims payment procedures and related Claims matters. It also explains how the Company will coordinate Your benefits with another plan.

I. CLAIMS POLICIES AND PROCEDURES

The benefits of the Policy are based on the assumption that the Covered Person is enrolled in Medicare [Part A] [and] [Part B]. The Company may pay the benefits directly to You, to the Physician, or to the Hospital.

You should present Your UnitedHealthcare identification card along with Your Social Security Medicare identification on Your first visit to the Physician or Hospital. Most Providers bill both Medicare and the Company for You. However, You may request that the Provider contact the Company for billing authorization and procedure.

PAYMENT OF BENEFITS. The Company will pay a benefit under the Policy for the Covered Expense that a Covered Person incurs due to Sickness or Injury [when the Covered Expense exceeds the [Calendar][Plan] Year Deductible and any other Deductible that may apply]. Benefits will be paid as set forth in the Schedule of Benefits. Benefits will not exceed the Lifetime Policy Maximum or any other maximums or limits set forth in the Policy. Benefits are subject to the Exclusions and Limitations specified in the Policy. The Definitions and all other terms and conditions of the Policy that may limit or exclude benefits also apply in determining the payment of the benefits.

NON-DUPLICATION OF BENEFITS. Benefits provided under the Policy will not duplicate any benefits paid by Medicare. The combined benefits provided under the Policy and Medicare or other coverage will never exceed one hundred percent (100%) of the charges incurred for medical services and supplies. Additionally, if a service is covered under more than one provision of the Policy, benefits will be provided under the provision that provides the greatest benefit, but not under both provisions.

MEDICARE ASSIGNMENT. If a Provider of services accepts Medicare assignment, the Company's payment will be limited to the difference between the amount paid by Medicare and the approved amount under Medicare [or the Company's reimbursement level, whichever is greater], subject to any benefit limitations, Deductibles, Copayments and Coinsurance set forth in the Schedule of Benefits.

LIMITATION OF LIABILITY. The Company shall not be obligated to pay any benefits under the Policy for any Claims if the proof of loss for such Claim was not submitted within the period provided, unless it is shown that: (1) it was not reasonably possible to have submitted the proof of loss within such period; and (2) the proof of loss was submitted as soon as it was reasonably possible.

In no event will the Company be obligated to pay benefits for any Claim if the proof of loss for such Claim is not submitted to the Company within one (1) year after the date of loss, except in the case of legal incapacity of the Covered Person.

CLAIMS PROCESSING. The Company reviews and evaluates all service benefit payment submissions for Medical Necessity and the possibility of billing irregularities. The review relies on and complies with the American Medical Association guidelines and the Current Procedural Terminology system coding standards. The Company may adjust or decline benefit payments consistent with the evaluation findings.

NOTICE OF CLAIM. A written notice of Claim must be furnished to the Company within twenty (20) days after a covered loss occurs or begins, or as soon thereafter as reasonably possible.

The Company, upon receipt of notice of Claim, will furnish to the Insured Person such forms as are usually furnished for filing proof of loss. If such forms are not furnished within fifteen (15) days after the giving of such notice, the Insured Person shall be deemed to have complied with the requirements of the Policy as to the proof of loss upon submitting, within the time fixed in the Policy for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which a Claim is made.

PROOF OF LOSS. Written proof of loss must be furnished to the Company at its office within ninety (90) days after the date of the loss. The Company will not reduce or deny a Claim for failure to furnish such proof within the time required, provided such proof is furnished as soon as reasonably possible. Except in the absence of legal capacity, the Company will not accept proof more than one (1) year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIMS. Benefits for incurred medical expenses that are covered under the Policy will be paid within thirty (30) days of receipt of a proper Claim by the Company. If a Claim does not contain all of the information necessary to pay or deny the Claim, the Company will request the required additional information within thirty (30) days of receipt of the Claim by the Company. If the requested information is not provided within forty-five (45) days of the date it is requested, the Company will deny the Claim and provide the reasons for denial in writing.

PAYMENT OF BENEFITS TO INSURED PERSON. All benefits, unless assigned under the Policy, are payable to the Insured Person whose Injury or Sickness, or whose covered Dependent's Injury or Sickness, is the basis of a Claim.

DEATH OR INCAPACITY OF INSURED PERSON. In the event of the Insured Person’s death or incapacity and in the absence of written evidence to the Company of the qualification of a guardian for the Insured Person’s estate, the Company may, in its sole discretion, make any and all payments of benefits under the Policy to the individual or institution that, in the opinion of the Company, is or was providing the Insured Person’s care and support.

ASSIGNMENTS. Benefits for Covered Expenses may be assigned by the Covered Person to the person or Provider rendering the services. No such assignment will bind the Company prior to the payment of the benefits assigned. The Company will not be responsible for determining an assignment’s validity. Payment of assigned benefits will be made directly to the assignee unless a written request not to honor the assignment, signed by the Covered Person and the assignee, is received prior to payment.

LEGAL ACTIONS. Any Person may not bring legal action for benefits against the Company:

1. Until at least sixty (60) days after proof of loss is sent to the Company as required; or
2. More than three (3) years after the time for submitting proof has ended.

PHYSICAL EXAMINATIONS. The Company, at its expense, may:

1. Have a Covered Person examined, as often as reasonably necessary, while any Claim is pending; and
2. In the case of death of a Covered Person, have an autopsy made, where allowed by law, if a Claim for benefits is made.

II. COORDINATION OF BENEFITS

The Company may coordinate benefits with benefits available under other similar health insurance policies. Coordination of Benefits between policies may result in a reduction in the amount of benefits ordinarily payable, so that the Covered Person never receives a total, from all Plans, of more than 100% of Allowable Expense incurred. All benefits provided under the Policy are subject to this coordination provision.

What is a Plan?

A "Plan", as used in this Coordination of Benefits provision, means any of the following policies that provide benefits or services for medical or surgical treatment:

1. Group, blanket or franchise insurance coverage;
2. Prepaid coverage under service plan contracts, or under group or individual practice;
3. Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organizations plans;
4. Any coverage in group, group-type and individual automobile "no-fault" and traditional automobile "fault" type plans;
5. Medicare or other governmental benefits, not including a state plan under Medicaid, and not including a Plan when, by law, its benefits are in excess to those of any private insurance Plan or other non-governmental Plan; or
6. Any coverage under group-type contracts that is not available to the public and can only be obtained and maintained because of membership in or association with a particular organization or group.

Each Plan, or other arrangement for coverage described above, is a separate Plan. If a Plan has two parts and the coordination of benefits provisions only applies to one part, each part is a separate Plan. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no Coordination of Benefits between those separate contracts.

What is an Allowable Expense?

Allowable Expense means the usual, customary and reasonable charge for any necessary health care service or supply when the service or supply is covered at least in part under any of the plans involved. When a plan provides benefits in the form of services or supplies rather than cash payments, the reasonable cash value of each service rendered or supply provided shall be considered an allowable expense. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an allowable expense under the above definition unless the Covered Person's stay in a private hospital room is considered Medically Necessary under at least one of the plans involved.

ORDER OF BENEFIT DETERMINATION RULES

The following rules determine the order of benefit payment:

1. A Plan without a Coordination of Benefits provision pays before one with such a provision;
2. A Plan which covers a person other than as a Dependent pays before a Plan which covers a person as a Dependent;
3. When rules 1 through 2 do not establish the order of benefit determination, the Plan covering the Person for a longer period pays first; however:
    a. The Plan covering the person as a laid-off or retired employee, or as a Dependent of a laid-off or retired employee, will pay after any other Plan covering that person as a full-time employee, or Dependent of a full-time employee; and
    b. If the other Plan does not have an Order of Benefit Determination Rule regarding laid-off or retired employees, then the provisions of rule 3.a. will not apply.

EFFECT ON BENEFITS

Benefits will be reduced when the Policy is secondary to one or more other Plans. Benefits will be reduced when the sum of:

1. The benefits payable for the Allowable Expense under this Plan without this provision; and
2. The benefits payable for the Allowable Expense under the other Plans, without this provision, whether or not a Claim is made, exceed the Allowable Expense in a [Calendar][Plan] Year. Thereafter, benefits will be reduced so that coordination with benefits payable under the other Plans does not total more than 100% of the Allowable Expense.

RIGHT TO RECEIVE AND RELEASE INFORMATION. For determining the applicability and implementing the terms of this Coordination of Benefits provision or any provision of similar purpose of any other Plan, the Company may release or obtain from any insurance company or other organization or person any information, with respect to any Covered Person, which the Plan deems to be necessary for such purposes. Any Covered Person claiming benefits must furnish information necessary to implement this provision.

REIMBURSEMENT OF PAYMENT. Payments made by any organization may be reimbursed by the Company subject to Policy limitations. Such reimbursements will fully discharge the Company's liability under the Policy.

RIGHT OF RECOVERY. Whenever payments for Covered Expenses exceed the maximum payment necessary to satisfy the Coordination of Benefits provisions, the Company may recover such excess payments. The term "payments for Covered Expenses" includes the reasonable cash value of any benefits provided in the form of services.

THIRD PARTY LIABILITY AND NON-DUPLICATION OF BENEFITS

1. Third Party Liability. Expenses incurred due to liable third parties are not covered.

   Health care expenses incurred by a Covered Person for which a third party or parties or a third party's (parties') insurance company (collectively, "liable third party") is liable or legally responsible by reason of negligence, a wrongful intentional act, or the breach of any legal obligation on the part of such third party, are expressly excluded from coverage under this Certificate. However, in all cases, the Company will pay for the arrangement or provision of health care services for a Covered Person that would have been Covered Services except that they were required due to a liable third party, in exchange for the agreement as expressly set forth in the section of this Certificate captioned "The Company's Right to the Repayment of a Debt as a Charge Against Recoveries From Third Parties Liable for a Covered Person's Health Care Expenses."

   The Company's Right to the Repayment of a Debt as a Charge Against Recoveries From Third Parties Liable for a Covered Person's Health Care Expenses. Expenses incurred by a Covered Person for which a third party or parties or a third party's (parties') insurance company (collectively, "liable third party") is liable or legally responsible by reason of negligence, a wrongful intentional act, or the breach of any legal obligation on the part of such third party, are expressly excluded from coverage under this Certificate. However, in all cases, the Company will pay for the arrangement or provision of health care services for a Covered Person that would have been Covered Services except that they were required due to a liable third party, in exchange for the following agreement:

   If a Covered Person is injured by a liable third party, the Covered Person agrees to give the Company, or its representative, agent or delegate, a security interest in any money the Covered Person actually recovers from the liable third party by way of any final judgment, compromise, settlement or agreement, even if such money becomes available at some future time.

   If the Covered Person does not pursue, or fails to recover (either because no judgment is entered or because no judgment can be collected from the liable third party), a formal, informal, direct or indirect claim against the liable third party, then the Covered Person will have no obligation to repay the Covered Person's debt to the Company, which debt shall include the cost of arranging or providing otherwise covered health care services to the Covered Person for the care and treatment that was necessary because of a liable third party.

The security interest the Covered Person grants to the Company, its representative, agent or delegate applies only to the actual proceeds, in any form, that stem from any final judgment, compromise, settlement or agreement relating to the arrangement or provision of the Covered Person's health care services for injuries caused by a liable third party.

2. Non-Duplication of Benefits

   a. Workers' Compensation. The Company shall not furnish benefits under the Policy to any Covered Person which duplicate benefits the Covered Person is entitled to under any Workers' Compensation law.

      In the event of a dispute regarding the Covered Person's receipt of benefits under Workers' Compensation laws, the Company will provide the benefits described in the Policy until resolution of the dispute.

      In the event the Company provides benefits which duplicate the benefits the Covered Person is entitled to under Workers' Compensation law, the Covered Person agrees to reimburse the Company for all such benefits provided by the Company immediately upon obtaining any monetary recovery. The Covered Person shall hold any sum collected as the result of a Workers' Compensation action in trust for the Company. Such sum shall equal the lesser of the amount of the recovery obtained by the Covered Person or the benefits furnished to the Covered Person by the Company on account of each incident.

      The Covered Person agrees to cooperate in protecting the interests of the Company under this provision. The Covered Person must execute and deliver to the Company any and all liens, assignments or other documents necessary to fully protect the right of the Company, including, but not limited to, the granting of a lien right in any Claim or action made or filed on behalf of the Covered Person.

   b. TRICARE Benefits. The Company shall not furnish benefits under the Policy which duplicate the benefits to which the Covered Person is entitled under TRICARE. If payment is made by the Company in duplication of the benefits available under TRICARE, the Company may seek reimbursement up to the amount of benefits which duplicate such benefits under TRICARE.

c. Automobile, Accident or Liability Coverage. The Company shall not furnish benefits which duplicate benefits the Covered Person is entitled to under any automobile, Accident or liability coverage. The Covered Person is responsible for taking whatever action necessary to obtain the available benefits of such coverage, and will notify the Company of receipt of such available benefits. If payment is provided by the Company in duplication of the benefits under other automobile, Accident or liability coverage, the Company may seek reimbursement for the duplicate benefits. Should the cost of Covered Services exceed the benefits under any other liability coverage pursuant to this section, the Policy benefits will be provided over and above such liability coverage.

SECTION THREE

Covered Person Eligibility

- Who is a Covered Person?
- Termination of Benefits

I. WHO IS A COVERED PERSON?

There are two kinds of Covered Persons: the Insured Person who enrolls under the Policy through his or her Employer or former Employer, and the Insured Person's eligible Dependents.

The coverage provided under the Policy is made available to You because of Your retirement from Your Employer or former Employer. In order for You to participate in the Employer's Retiree welfare benefit plan, certain requirements must be satisfied. These requirements may include probationary or waiting periods. The specific time periods and other standards for participation in the Employer's Retiree welfare benefit plan are determined by the Employer, or state and/or federal law. Eligibility requirements are described in general terms below. For more specific eligibility information, You should contact the Human Resources or benefits department of Your Employer or former Employer.

ELIGIBILITY REQUIREMENTS

The Insured Person must be a former employee of the Employer: (1) who has met all the eligibility requirements established by the Employer for participation in the Employer's Retiree welfare benefit plan (including, but not limited to, having attained retirement eligibility under the Employer's Retiree welfare benefit plan); [(2) who is age 65 or older]; and (3) who is eligible for, and enrolled in, Medicare [Part A] [and] [Part B]. Eligible Dependents of the Insured Person may be enrolled under the Policy if such Dependent is: (1) eligible for coverage under the Employer's Retiree welfare benefit plan; and [(2) is eligible for, and enrolled in, Medicare [Part A] [and] [Part B].]

NOTIFICATION OF ELIGIBILITY CHANGE. Any Covered Person who no longer satisfies the eligibility requirements is not covered by the Policy and has no right to any of the benefits described in the Certificate. The Company must be notified within thirty-one (31) days of any condition that may affect eligibility.

EFFECTIVE DATE. An Insured Person or his or her Dependent(s) may be enrolled for coverage under the Policy in one of the four ways described below. Subject to payment of the applicable premium and the Company's receipt of the appropriate enrollment forms, and in accordance with the provision below, Personal or Dependent Insurance becomes effective as indicated in this section.

1. Open Enrollment. If a Retiree or a Dependent enrolls during an Open Enrollment Period, coverage will become effective on the first day of the Insurance Month following the end of the Open Enrollment Period.
2. Within 90 Days of an Eligibility Date. If a Retiree or eligible Dependent enrolls within ninety (90) days after first becoming eligible for coverage under the Policy, Personal Insurance or Dependent Insurance will become effective on the first day of the Insurance Month following the date of enrollment.

3. Late Enrollment. In the event a Retiree or eligible Dependent who is eligible for coverage under the Policy declines enrollment for such coverage within ninety (90) days of becoming eligible, and subsequently requests enrollment, such Retiree or Dependent will not be eligible for coverage under the Policy unless the Retiree or Dependent is eligible for Special Enrollment as described below.

4. Special Enrollment. A Special Enrollment Period of [31–90 days] is provided for Retirees or eligible Dependents eligible to enroll for coverage under the Policy if the Retiree or eligible Dependent:

    a. Had other group health insurance coverage at the time he or she was eligible to enroll under the Policy;

    b. Was given the opportunity to enroll;

    c. Certified in writing that having such other coverage was the reason for declining enrollment under the Policy;

    d. Was notified that the failure to provide the certification would result in a delay in future coverage under the Policy; and has lost or will lose such other health insurance coverage due to exhaustion of a COBRA continuation provision, a loss of eligibility for the other coverage, or a termination of Employer contributions for the other coverage.

    The Effective Date of coverage for the Retiree or eligible Dependent enrolled during this Special Enrollment Period will be the first day of the Insurance Month following the date on which the Retiree or Dependent enrolled.

II. TERMINATION OF BENEFITS

INDIVIDUAL TERMINATIONS. A Covered Person's coverage will terminate on the earliest of the following:

1. The date the Policy terminates;
2. The last day of the Insurance Month in which the Covered Person requests termination;
3. The last day of the last Insurance Month for which premium payment is made on behalf of the Covered Person;
4. The date the Covered Person ceases to be eligible for coverage under the Policy; or
5. With respect to any particular insurance benefit, the date that benefit terminates.

FRAUD OR DECEPTION. The Company may terminate or rescind the Policy or a Covered Person's coverage thereunder, if the following are true:

1. Such Covered Person knowingly provides the Company with fraudulent information upon which the Company relies; and
2. Such information materially affects the Covered Person's eligibility for enrollment or benefits under the Policy. In such instance, the Company shall send a written notice of termination or rescission to the Insured Person. It shall also refund any unearned premium which applies after the date of termination or rescission.

FRAUDULENT USE OF IDENTIFICATION CARD. A Covered Person's eligibility for coverage under the Policy shall immediately terminate if such Covered Person permits the use of his or her insurance identification card by any other person. In such instance, the Company shall mail a written notice of termination to the Covered Person. It shall also refund any unearned premium which applies after the date of termination.

Please Note: No coverage shall be in force and no benefit shall be payable for charges which are incurred after the date a Covered Person's coverage terminates for any reason under this Certificate, except as provided by any applicable continuation coverage which the Covered Person elects and for which premium is submitted in a timely manner.

[COVERAGE FOLLOWING TERMINATION OF INDIVIDUAL COVERAGE. A Covered Person may be entitled to the following continuation coverage options following termination of coverage:

COBRA Continuation Coverage. If the Insured Person's Employer or former Employer is subject to the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), You may be entitled to temporarily extend Your coverage under the health plan at group rates, plus an administration fee, in certain instances where Your coverage under the health plan would otherwise end. The Insured Person's former Employer is legally responsible for informing You of Your specific rights under COBRA. Therefore, please consult with the Insured Person's former Employer regarding the availability and duration of COBRA continuation coverage.]

CERTIFICATE OF CREDITABLE COVERAGE. According to the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), a certificate of Creditable Coverage will be provided to the Insured Person by the Company when the Insured Person or a Dependent ceases to be eligible for benefits under the Group Policyholder's health benefit plan. A certificate of Creditable Coverage may be used to reduce or eliminate a Pre-Existing Condition exclusion period imposed by a subsequent health plan. Creditable Coverage information for Dependents will be included on the Insured Person's Certificate, unless the Dependent's address of record or coverage information is substantially different from the Insured Person's. Please contact the Company's customer service department if You need a duplicate certificate of Creditable Coverage. If You meet HIPAA eligibility requirements, You may be able to obtain individual coverage using Your certificate of Creditable Coverage.

SECTION FOUR

Decisions Regarding Benefits

- Appealing a Decision Relating to Benefits
- The Appeals Process
- Statement of ERISA Rights

I. APPEALING A DECISION RELATING TO BENEFITS

A Covered Person and the Company may not always agree that a Claim or request for services has been reviewed properly. When this happens, the Covered Person is encouraged to call the Company's Customer Service Department. The Company's Customer Service Department coordinator will assist the Covered Person and attempt to find a solution to the Covered Person's problem or grievance.

If the Covered Person feels that his/her problem or grievance requires additional action, the Covered Person may file a formal appeal. The Company's appeals procedures are designed to deliver a timely response and resolution to a Covered Person's problem or grievance. This is done through a process that includes a thorough and appropriate investigation, as well as an evaluation of the problem or grievance.

The Covered Person may submit written comments, documents, records, and any other information relating to the appeal, regardless of whether this information was submitted or considered in the initial determination. The Covered Person may designate a representative to file an appeal on their behalf by providing written notice that includes the issue in dispute, the Covered Person's signature and the representative's signature.

The appeal will be reviewed by an individual who is neither the individual who made the initial determination that is the subject of the appeal nor the subordinate of that person. If the appeal involves a clinical issue, the necessity of treatment, or the type of treatment or level of care proposed or utilized, the determination will be made by a medical reviewer who has the education, training and relevant expertise in the field of medicine necessary to evaluate the specific clinical issues that serve as the basis of the appeal.

For appeals involving a decision based on Medical Necessity, the Company's written response will describe the criteria or guidelines used and the clinical reasons for its decision and the option to request external review. For determinations that the services are not Covered Services, the response will specify the provisions in the Certificate that exclude that coverage.

The Covered Person may obtain, upon request and free of charge, copies of all documents, records and other information relevant to the appeal.

II. THE APPEALS PROCESS

If the Covered Person disagrees with a Company decision regarding an authorization or a claim, the dispute shall be directed to the Company either by telephone or in writing. The appeal must be filed within one hundred eighty (180) days of receiving a denial notice or explanation of benefits. To initiate the standard appeal, the Covered Person may call the Company's Customer Service Department to request an appeal form or write the Appeals Department at the address below:

Appeals Department
[P.O.Box XXXXX]
Telephone: [1-XXX-XXX-XXXX]
Facsimile: [1-XXX-XXX-XXXX]

Urgent Appeal: Appeals involving an imminent and serious threat to the Covered Person's health including, but not limited to, severe pain or the potential loss of life, limb or major bodily function, will be immediately referred to the Company's clinical review personnel. Urgent appeal requests may be initiated by calling Customer Service or faxing a written request to the Appeals Department. If the request does not meet the criteria for an Urgent Appeal, it will be reviewed under the standard appeal process. If the appeal requires urgent review, the Company will make a determination not later than seventy-two (72) hours of the Company's receipt of the appeal.

Standard Appeal: If the appeal does not qualify as an urgent appeal, it will be reviewed as a standard appeal. The Appeals Department will provide a written response regarding the outcome within thirty (30) calendar days from receipt of the appeal for an authorization denial and within sixty (60) calendar days from receipt of an appeal for a claim denial.

QUALITY OF CARE/QUALITY OF SERVICE REVIEW

All quality of clinical care and quality of service complaints are investigated by the Company. The Company conducts reviews by investigating the complaint and consulting with treating Providers and other UnitedHealthcare internal departments. Medical records are requested and reviewed as necessary and, as such, the Covered Person may need to sign an authorization to release medical records. The Company will notify the Covered Person in writing regarding the disposition of the complaint within thirty (30) days of receipt of the complaint. Please be aware that the results of the quality of clinical care review are confidential and protected from legal discovery in accordance with state law.

INDEPENDENT REVIEW. If you receive an adverse determination of an appeal to the Company and have exhausted the Company's appeals procedures, you may direct the Company to seek a review of that determination by an independent review organization. An adverse determination is a determination that services furnished or proposed to be furnished are not Medically Necessary or are experimental or investigational. You may request an expedited appeal to the independent review organization if failure to proceed in an expedited manner may jeopardize the life or health of the Covered Person or the Covered Person's ability to regain maximum function. In order to obtain an independent review, you must be required to pay $500 or more for the service that is the subject of the adverse determination. A request for an independent review must be accompanied by a $25 fee.

Independent reviews will be conducted in accordance with applicable state law.

III. STATEMENT OF ERISA RIGHTS

Contact Your Employer's Benefit Administrator to learn whether Your plan is an employee welfare benefit plan as defined by the Employee Retirement Income Security Act of 1974 (ERISA). If You participate in an ERISA employee welfare benefit plan, ERISA provides You with certain rights and protections.

1. All benefit determination or claim procedures are described for You in Your summary plan description.
2. If You receive an adverse benefit determination, a determination notice will be forwarded to You, electronically or in writing, within a reasonable time not to exceed ninety (90) days of the date the Claim is submitted.
3. You may appeal any adverse benefit determination. ERISA provides You with at least one hundred eighty (180) days from the day You receive notice of an adverse benefit determination to appeal it. You will be provided an opportunity to submit relevant information in support of Your appeal.
4. ERISA provides for up to two (2) mandatory appeal levels for any adverse determination. You have a right to bring a civil action on any adverse determination that You believe, after participating in the mandatory appeal process, was incorrectly made under Your plan.
5. ERISA provides that, in connection with any appeal of an adverse benefit determination, You have the right to request access to and receive a free copy of any and all documents, records, and other information, as follows:
    a. Relied on in making Your benefit determination;
    b. Submitted, considered, or generated in the course of making Your benefit determination;
    c. Which demonstrates compliance with administrative safeguards concerning consistent application of the plan document among similar claims; and
    d. Any plan Policy statement or guidance regarding Your diagnosis.
6. ERISA provides that most benefit appeal determination notices will be forwarded to You, in writing, within a reasonable period not to exceed sixty (60) days from the date of the plan's receipt of the benefit appeal request.
7. Your participation in a voluntary appeal level does not affect Your legal review rights, or any rights You have under Your plan. Any statute of limitations will be tolled during the time You participate in a voluntary review level.
8. You and Your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact Your local U.S. Department of Labor office and Your state insurance regulatory agency.

SECTION FIVE

Definitions

The Company is dedicated to making its services easily accessible and understandable. To help You understand the precise meanings of many terms used to explain Your benefits, we have provided the following definitions. These definitions apply to the capitalized terms used in Your Certificate, as well as the Schedule of Benefits.

ACCIDENT means an acute Injury that happens suddenly, unexpectedly and without design of the person injured. An Accident does not include any activity which ordinarily would not injure a person in good health.

ACUPUNCTURE means a Medically Necessary treatment provided by a licensed acupuncturist that involves stimulation of anatomical points on the body by a variety of techniques.

ACUPRESSURE means a Medically Necessary treatment provided by a licensed Provider that involves the compression of blood vessels by means of needles in surrounding tissues.

ADMINISTRATOR means an appropriately licensed organization with whom the Company has contracted to perform administration services. Applicable Administrators are identified under the Administrators section of the Certificate.

ALCOHOL, DRUG OR OTHER SUBSTANCE ABUSE means the addictive relationship with any drug or alcohol characterized by either a physical or psychological relationship, or both, that interferes with the individual's social, psychological or physical adjustment to the activities of daily living on a recurring basis. Alcohol, Drug or Other Substance Abuse does not include addiction to, or dependency on, tobacco, tobacco products or foods.

CALENDAR YEAR means January 1, 12:00 a.m. to December 31, 11:59 p.m. of the same year.

CALENDAR YEAR DEDUCTIBLE means the amount of Covered Expense shown on the Schedule of Benefits that a Covered Person is responsible for paying each Calendar Year before benefits are payable under the Policy. Covered Expense that a Covered Person has to pay due to any additional Deductibles or any Copayments will not be applied toward satisfying the Calendar Year Deductible.

CERTIFICATE means this summary of the terms of Your benefits, along with the Schedule of Benefits. The Certificate is attached to and is part of the Policy issued to the Group Policyholder and is subject to the terms of the Policy.

CLAIM means notification in a form acceptable to the Company that a Covered Service has been rendered or furnished to a Covered Person. This notification must set forth in full the details of such Covered Service as required by the Company.

COBRA means those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 (as amended) that regulate the conditions and manner in which an Employer must offer continuation of group health insurance to Covered Persons whose coverage would otherwise terminate under the terms of the Policy.

COGNITIVE REHABILITATION THERAPY is therapy for the treatment of functional deficits as a result of traumatic brain injury and cerebral vascular insult. It is intended to help in achieving the return of higher level cognitive ability. This therapy is direct (one-on-one) patient contact.

COINSURANCE, if any is required, means that portion of the Covered Expense which is not payable as a benefit due to the Percentage Payable being less than one hundred percent (100%). Coinsurance does not include any Deductibles or Copayments. [Coinsurance does not include any amounts payable by the Covered Person because Preauthorization was not obtained.] Coinsurance does not include any amounts payable by the Covered Person which are not considered as Covered Expense under the Policy.

COINSURANCE MAXIMUM means the Coinsurance Maximum shown on the Schedule of Benefits. When a Covered Person has paid an amount of Coinsurance during the Calendar Year equal to one of the Coinsurance Maximums, then the Percentage Payable will be one hundred percent (100%) for all additional Covered Expenses the Covered Person incurs during the rest of that Calendar Year for the type of Provider for which the Coinsurance Maximum has been reached.

COMPANY means UnitedHealthcare Insurance Company.

COMPLICATIONS OF PREGNANCY means conditions requiring Inpatient confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, puerperal infection and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, Physician-prescribed rest during the period of pregnancy, morning Sickness, hyperemesis gravidarum, pre-eclampsia, and similar conditions associated with the management of a difficult pregnancy. A non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible, are considered Complications of Pregnancy.

COPAYMENT means that portion of Covered Expenses which is the responsibility of the Covered Person and which is shown as Copayments on the Schedule of Benefits. Copayments do not apply toward the Deductible and do not accrue toward the Coinsurance Maximum. Copayments will continue to be required after the Coinsurance Maximum has been reached.

COVERED EXPENSE means an expense that is incurred for a Medicare Eligible Expense for a Covered Service provided to a Covered Person while that Covered Person is insured under the Policy, and does not exceed the Medicare Eligible Expense and does not exceed the smallest of any Policy Maximum that may apply to the Covered Expense. For any other Covered Service under the Policy which is not a Medicare Eligible Expense, a Covered Expense shall not exceed the lesser of billed charges or Usual and Customary Charges and shall not exceed the smallest of any Policy Maximum that apply to the Covered Expense.

COVERED PERSON means the Insured Person or the Dependent(s) of the Insured Person who are insured under the Policy. Covered Persons are sometimes called “You” and “Your.”

COVERED SERVICE means a service or supply that is:

1. Performed, prescribed, directed or authorized by a Provider; and
2. Medically Necessary for the treatment of an Injury or Sickness.

CREDITABLE COVERAGE means coverage under any of the following:

1. A self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employer Retirement Income Security Act of 1974;
2. A group health benefit plan provided by a health insurance carrier or health maintenance organization;
3. An individual health insurance Policy or evidence of coverage;
4. Part A or Part B of Title XVIII of the Social Security Act (Medicare);
5. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928; (medical and dental care for certain members and former members of the armed services);
6. Chapter 55 of Title 10, United States Code;
7. A medical care program of the Indian Health Service or of a tribal organization;
8. A state health benefits risk pool;
9. A health plan offered under Chapter 89 of Title 5, United States Code (Federal Employee Health Benefit Program;
10. A public health plan (as defined in federal regulations);
11. A health benefit plan under Section 5 (e) of the Peace Corps Act; or
12. Title XXI of the Social Security Act (State Children's Health Insurance Program).

Creditable Coverage does not include coverage consisting solely of the following:

1. Coverage only for Accidents, or disability income insurance, or any combination thereof;
2. Liability insurance, or coverage issued as a supplement to liability insurance;
3. Workers' Compensation or similar insurance;
4. Automobile medical payment insurance;
5. Credit-only insurance;
6. Coverage for on-site medical clinics; or
7. Other similar insurance coverage specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

Creditable Coverage does not include any of the following, if offered separately:

1. Limited scope dental or vision benefits;
2. Long term care, nursing home care, home health care, community-based care, or any combination thereof;
3. Medicare supplemental health insurance;
4. Coverage supplemental to coverage under Chapter 55 of Title 10, United States Code; or
5. Similar supplemental coverage provided to coverage under a group health plan.

Creditable Coverage does not include either of the following, if offered as independent, non-coordinated benefits:

1. Coverage only for a specified disease or illness; or
2. Hospital indemnity or fixed indemnity insurance.

CUSTODIAL CARE means care and services that assist an individual in the activities of daily living. Examples include: assistance in walking, getting in or out of bed, bathing, dressing, and using the toilet; feeding or preparation of special diets; and supervision of medication that usually can be self-administered. Custodial Care includes all homemaker services, Respite Care, convalescent care or extended care not requiring skilled nursing. Custodial Care does not require the continuing attention of trained medical or paramedical personnel. The mere provision of Custodial Care by a medical professional, such as a Physician, licensed nurse or registered therapist, does not mean the services are not custodial in nature. If the nature of the services can be safely and effectively performed by a trained non-medical person, the services will be considered Custodial Care.

DEDUCTIBLE means the amount of Covered Expense a Covered Person must pay before benefits become payable under the Policy.

DEPENDENT means:

1. A person who is the Insured Person's Spouse [or Domestic Partner] who is not legally separated from the Insured Person; or
2. A person [of any age] [age 65 or older] who is [(1)] eligible for coverage under the Employer's Retiree welfare benefit plan[.][;] [and] [(2) is eligible for, and enrolled in, Medicare] [Part A] [and] [Part B]].

DEPENDENT INSURANCE means the group health insurance provided by the Policy for Dependent(s) of the Insured Person.

DIABETES EQUIPMENT means any of the following: blood glucose monitors, including monitors designed to be used by blind individuals; insulin pumps and associated appurtenances; insulin infusion devices; and podiatric appliances for the prevention of complications associated with diabetes.

DIABETES SUPPLIES mean any of the following: test strips for blood glucose monitors; visual reading and urine test strips; lancets and lancet devices; insulin and insulin analogs; injection aids; syringes; prescriptive and non-prescriptive oral agents for controlling blood sugar levels; and glucose emergency kits.

[DOMESTIC PARTNER means an individual (other than a relative of the Insured Person) who for the Calendar Year: (1) has his or her personal place of abode at the home of the Insured Person; (2) is a member of the Insured Person's household; and (3) the Insured Person has designated as a Domestic Partner with the Administrator, in accordance with the Administrator's reasonable procedures; provided, however, that an individual shall not be considered a Domestic Partner if the Insured Person has a Spouse or other Domestic Partner.]

DRUGS OR PRESCRIPTION DRUGS mean only those pharmaceutical substances required by law to be dispensed by prescription.

DURABLE MEDICAL EQUIPMENT means durable items or appliances that:

1. Are Medically Necessary;
2. Are able to withstand repeated use;

3. Are designed to serve a medical purpose;
4. Generally are not useful to a Covered Person in the absence of a medical condition, Injury or Sickness;
5. Are not disposable;
6. Are not customarily found in a Physician's office; and
7. Are needed for functional rather than cosmetic reasons.

This term does not include charges for the repair or maintenance of such equipment.

EFFECTIVE DATE means, with respect to any Covered Person, the date such Covered Person is first insured under the Policy.

EMERGENCY MEDICAL CONDITION means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the Covered Person's health in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part;
4. In the case of a pregnant woman, an Emergency Medical Condition exists if the Covered Person is in active labor, meaning labor at a time in which either of the following would occur:
    a. there is inadequate time to effect safe transfer to another Hospital prior to delivery; or
    b. a transfer may pose a threat to the health and safety of the Covered Person or the unborn child.

[An Emergency Medical Condition does not include services provided at a Hospital emergency room that a prudent layperson could have obtained at a Physician's office or where there is a pattern of the Covered Person visiting multiple emergency rooms for the purpose of seeking prescriptions for pain medications.]

EMERGENCY SERVICES means Covered Services that are:

1. Furnished by a Provider qualified to furnish Emergency Services; and
2. Needed to evaluate or stabilize a medical emergency. (See the definition of Emergency Medical Condition.)

EMPLOYER means the Group Policyholder approved by the Company for participation in the coverage provided by the Policy.

EXPERIMENTAL AND/OR INVESTIGATIONAL PROCEDURES mean those particular services, supplies or treatments not covered under the Policy as described in the Exclusions and Limitations sections of the Certificate.

FACILITY means a health care or residential Facility that is duly accredited by and licensed by the

state in which it operates to provide medical Inpatient, residential day treatment, partial Hospitalization, Skilled Nursing Services or Outpatient care, or a Facility for the diagnosis or treatment of Alcohol, Drug, or Other Substance Abuse, or mental illness.

GROUP POLICYHOLDER means the person, partnership, corporation or trust as shown on the Policy Information Page of the Policy.

HOME HEALTH AIDE means a person who has completed Home Health Aide training, as required by the state in which the individual is working. Home Health Aides must work under a plan of care ordered by a Physician and under the supervision of a licensed nurse or licensed therapist.

HOME HEALTH AIDE SERVICES mean Medically Necessary personal care such as bathing, exercise assistance and light meal preparation, provided by trained individuals and ordered along with skilled nursing and/or therapy visits.

HOME HEALTH CARE means the Home Health Care provided by a certified Home Health Care Agency according to a Physician's written treatment plan for care of a Covered Person in the Covered Person's place of residence. Services appropriate to the needs of the individual patient are planned, coordinated and made available through a multidisciplinary health team.

HOME HEALTH CARE AGENCY means an organization duly licensed and certified or otherwise authorized as a Home Health Care Agency pursuant to the laws of the state in which the Covered Person resides and meets Medicare's requirements for Home Health Care agencies and which is engaged in arranging and providing nursing services, Home Health Care services, and other therapeutic and related services.

HOME HEALTH CARE VISIT means up to two (2) hours of skilled services by a registered nurse or licensed vocational nurse or licensed therapist, or up to four (4) hours of Home Health Aide Services.

HOSPICE means a specialized form of interdisciplinary health care for a Covered Person with a life expectancy of six (6) months or less due to a terminal illness. Hospice programs or services are designed to provide palliative care; alleviate the physical, emotional, social and spiritual discomforts of a Covered Person who is experiencing the last phase of life due to the existence of a terminal disease; and provide supportive care to the primary caregiver and family of the Covered Person receiving Hospice services.

HOSPICE CARE means the care provided to a Covered Person when the goal of treatment is to provide supportive care and counseling during the terminal phase of an illness. Hospice Care is provided through a hospice care agency for Covered Persons who have a terminal Sickness, for which the prognosis of life expectancy is six (6) months or less, and who no longer elect to pursue aggressive medical treatment for the terminal Sickness.

HOSPITAL means an acute care Facility operated pursuant to state laws and:

1. Is accredited as a Hospital by the Joint Commission on Accreditation of Health Care Organizations or by the Medicare program;
2. Is primarily engaged in providing, for compensation from its patients, diagnostic and surgical facilities for the care and treatment of injured or sick individuals by or under the supervision of a staff of Physicians;
3. Has 24-hour nursing services by registered nurses; and

4. Is not primarily a place for rest or Custodial Care, or a nursing home, convalescent home or similar institution.

INJURY means bodily Injury due to an Accident occurring while a Covered Person is insured under the terms and conditions of the Policy.

INPATIENT means being registered as an Inpatient in a Hospital or a Facility upon the recommendation of a Provider, and incurring charges for room and board.

INPATIENT SERVICES mean those Covered Services provided to a Covered Person in a Hospital or Skilled Nursing Facility bed that is not in the Outpatient department of such institution.

INSURANCE MONTH means that period of time:

1. Beginning at 12:00 a.m. Standard Time at the Group Policyholder's principal location on the first day of any calendar month; and
2. Ending at 11:59 p.m. on the last day of the same calendar month.

INSURED PERSON means the Retiree for whom coverage is in effect as provided by the Policy.

INTENSIVE CARE UNIT means a separate part of a Hospital or Facility that provides:

1. Treatment to patients in critical condition;
2. Continuous special nursing care or observation by trained and qualified personnel; and
3. Life-saving equipment.

INTRAMUSCULAR means an injection into the muscle.

INTRAVENOUS means an injection into the vein.

LATE ENROLLEE means a person or a Dependent who declined enrollment in the Policy when offered and who subsequently requests enrollment outside the designated Open Enrollment Period.

LEARNING DISABILITY means a condition which manifests as a significant discrepancy between estimated cognitive potential and actual level of educational performance, and which is not a result of generalized Mental Retardation, educational or psycho-social deprivations, psychiatric disorder or sensory loss.

LIFETIME POLICY MAXIMUM means the maximum amount of benefits payable under the Policy for all Covered Expenses incurred by a Covered Person while insured under the Policy. The Lifetime Policy Maximum is shown on the Schedule of Benefits. No further benefits will be paid after a Covered Person reaches the Lifetime Policy Maximum, and such Covered Person will no longer be insured under the Policy.

MATERNITY means prenatal and postnatal care, childbirth, or any Complications of Pregnancy of an Insured Person or the Insured Person's covered Dependent Spouse.

MEDICALLY NECESSARY (OR MEDICAL NECESSITY) means, for Covered Services eligible for payment under Section One, an intervention if recommended by the treating Physician and by the Company's medical director to be all of the following:

1. A health intervention for the purpose of treating a medical condition;

2. The most appropriate supply or level of service, considering potential benefits and harms to the Covered Person;

3. Known to be effective in improving health outcomes. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion. For new interventions, effectiveness is determined by scientific evidence; and

4. If more than one health intervention meets the requirements of 1 through 3 above, furnished in the most cost-effective manner that may be provided safely and effectively to the Covered Person. "Cost-effective" does not necessarily mean the lowest price.

A service or item will be covered under the Company health plan if it is an intervention that is an otherwise covered category of service or item, not specifically excluded, and Medically Necessary. An intervention may be medically indicated yet not be a covered benefit or meet the definition of Medical Necessity.

In applying the above definition of Medical Necessity, the following terms shall have the following meanings:

- The “treating Physician” means the Physician who has personally evaluated the Covered Person.
- A "health intervention" is an item or service delivered or undertaken primarily to treat (that is, prevent, diagnose, detect, treat, or palliate) a medical condition or to maintain or restore functional ability. A “medical condition” is a disease, Sickness, Injury, genetic or congenital defect, pregnancy or a biological or psychological condition that lies outside the range of normal, age-appropriate human variation. A health intervention is defined not only by the intervention itself, but also by the medical condition and the Covered Person’s indications for which it is being applied.
- "Effective" means that the intervention can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.
- "Health outcomes" are outcomes that affect health status as measured by the length or quality (primary as perceived by the patient) of a person's life.
- "Scientific Evidence" consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that suggest a causal relationship between the intervention and the health outcomes can be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive, but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential experimental biases. For existing interventions, the scientific evidence should be considered first and, to the greatest extent possible, should be the basis for determinations of Medical Necessity. If no scientific evidence is available, professional standards of care should be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions should be based on expert opinion. Giving priority to scientific evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive scientific evidence.

Existing interventions can meet the definition of Medical Necessity in the absence of scientific evidence if there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care or, in the absence of such standards, convincing expert opinion.

- A "new intervention" is one that is not yet in widespread use for the medical condition and Covered Person's indications being considered. New interventions for which clinical trials have not been conducted because of epidemiological reasons (i.e., rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care. If professional standards of care do not exist, or are outdated or contradictory, decisions about such new interventions should be based on convincing expert opinion.
- An intervention is considered cost-effective if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative.

MEDICARE means Hospital Insurance Plan (Part A) and the supplementary Medical Insurance Plan (Part B) provided under Title XVIII of the Social Security Act, as amended.

MEDICARE BENEFIT PERIOD means the period of time used by Medicare to measure Your coverage under Medicare Part A. Your first Benefit Period begins on the day You enter a Hospital as a Medicare patient. It ends sixty (60) days after You leave the Hospital (counting the day of Your discharge) or, if You have to go from the Hospital to a Skilled Nursing Facility, it ends sixty (60) days after You leave the Skilled Nursing Facility. If You are Hospitalized again within sixty (60) days, the second Hospital stay is considered part of Your first Medicare Benefit Period.

MEDICARE ELIGIBLE EXPENSE means expenses of the kind covered by Medicare, to the extent recognized as reasonable and Medically Necessary by Medicare. Payment of benefits under the Policy for Medicare Eligible Expenses will be based on the same payment conditions and determinations of Medical Necessity as are applicable under Medicare.

MEDICARE PART A OR PART B DEDUCTIBLE means the amount of health care charges Medicare requires You to pay before Medicare Part A or Part B benefits are paid.

MEDICARE PART B EXCESS CHARGES means the difference between the actual Medicare Part B approved amount and the Medicare-approved Part B charge for non-assigned Claims. The billed charges must not exceed any limitation established by Medicare or state law.

MENTAL RETARDATION AND RELATED CONDITIONS means conditions based on the following three criteria: intellectual functioning level (IQ) is below 70--75; significant limitations exist in two or more adaptive skill areas; and the condition is present from childhood (defined as age 18 or less.)

NEUROMUSCULAR SKELETAL DISORDERS means misalignments of skeletal structures and muscular weaknesses, imbalance and disorders related to the spinal cord, neck and joints. All such disorders must be documented and demonstrated through X-rays or bodily function limitations.

OPEN ENROLLMENT PERIOD means a period of time as specified in the application of the Group Policyholder and approved by the Company during which Retirees may enroll themselves and their eligible Dependents under the Policy. The Open Enrollment Period, if any, is shown on the Policy Information Page.

OUT-OF-POCKET EXPENSE MAXIMUM, if any, is shown on the Schedule of Benefits. When a Covered Person has paid an amount during the [Calendar][Plan] Year equal to the Out-of-Pocket Expense Maximum [including] [excluding] [Medical] [and] [Pharmacy] [Coinsurance] and the [Calendar][Plan] Year Deductible, then the Percentage Payable will be one hundred percent (100%) for all additional Covered Expenses the Covered Person incurs during the rest of that [Calendar][Plan] Year.

OUTPATIENT means receiving treatment from a Provider in a Facility other than on an Inpatient basis.

PERCENTAGE PAYABLE means the benefits payable under the Policy which are a percentage of the Covered Expense in excess of all Deductibles and Copayments. The Percentage Payable for each type of Covered Service is set forth in the Schedule of Benefits.

PERSONAL INSURANCE means the group health insurance provided by the Policy on Insured Persons.

PHYSICIAN means a licensed doctor of allopathy or osteopathy who is practicing within the scope of his or her licensure and any other practitioner of the healing arts who renders services within the scope of his or her licensure.

PLAN YEAR means any consecutive twelve-month period beginning on the Effective Date shown in the Policy [other than a Calendar Year].

POLICY means the Group Health Insurance Policy issued by the Company to the Group Policyholder.

POLICY ANNIVERSARY means the annual date stated as the “Policy Anniversary” on the Policy Information Page of the Policy.

POLICY EFFECTIVE DATE means the date stated as the “Policy Effective Date” on the Policy Information Page of the Policy.

PREAUTHORIZATION means the medical review process that examines the Medical Necessity of a procedure or service and that must be obtained by the Covered Person from the Company’s Administrator prior to receiving such procedure or service from a Provider. If Preauthorization is required, it must be obtained to avoid a reduction in benefits under the Policy.

PROVIDER means a person, group, Facility or other entity that is licensed or otherwise qualified to deliver any of the health care services described in this Certificate and any supplemental benefit materials.

REHABILITATION SERVICES mean the individual or combined and coordinated use of medical, physical, cognitive rehabilitation, occupational and speech therapy for training or retraining individuals disabled by Sickness or Injury.

RESPITE CARE means the short-term services provided to Covered Persons receiving authorized Hospice services who have disabilities that require care and/or supervision while allowing the caregivers temporary relief. Services may be provided:

1. In a nursing home or Hospital, and includes personal care, nursing intervention, supervision, meal preparation, and a room.

2. In an adult foster care home or personal care home, and includes personal care, housekeeping, supervision, meal preparation, transportation, and a room.

3. In an adult day health care Facility, and includes personal care, nursing services, supervision, meal preparation, and transportation.

4. In the individual's own home by a home care attendant or primary caregiver, and includes personal care, housekeeping, meal preparation, supervision, and transportation.

RETIREE means a former employee of the Employer who: (1) has met all the eligibility requirements established by the Employer for participation in the Employer's Retiree welfare benefit plan; [(2) is age 65 or older;] [(3)] is eligible for, and enrolled in, Medicare Part A and Part B; [and] [(4)] who is entitled to benefits under the Policy.

SEMI-PRIVATE ROOM RATE means the most common charge for a two-bed room in a Hospital, Facility, or Skilled Nursing Facility, as determined by the Company.

SICKNESS means a physical illness, disease or Complications of Pregnancy.

SIGNIFICANT BREAK IN COVERAGE means a period of sixty-three (63) consecutive days during all of which an individual does not have any Creditable Coverage. Waiting periods and HMO affiliation periods during which an individual does not have coverage are not taken into account in determining a Significant Break in Coverage.

SKILLED NURSING FACILITY means a comprehensive freestanding rehabilitation Facility or a specially designed unit within a Hospital licensed by the state in which it is doing business to provide Skilled Nursing Services.

SKILLED NURSING SERVICES mean the services provided directly by or under the direct supervision of licensed nursing personnel, including the supportive care of a Home Health Aide.

SKILLED REHABILITATION CARE means the care provided directly by or under the direct supervision of a licensed Provider acting within the scope of his or her licensure.

SPECIAL ENROLLMENT PERIOD means a period of time, mandated by the Health Insurance Portability and Accountability Act of 1996, where persons or Dependents who are not insured under the Policy may enroll for coverage as specified in the Special Enrollment provision.

SPOUSE means a legally recognized husband or wife under the laws of the state where the Policy is delivered.

SUBACUTE AND TRANSITIONAL CARE means levels of care needed by a Covered Person who does not require Hospital acute care, but who requires more intensive licensed Skilled Nursing Services than are provided to the majority of patients in a Skilled Nursing Facility.

SUBCUTANEOUS means an injection under the skin.

TEMPOROMANDIBULAR JOINT DYSFUNCTION means a condition affecting the upper or lower jawbone, or associated bone joints that is unrelated to any external traumatic episode.

TELEHEALTH means a health service, other than a Telemedicine service, delivered by a licensed

or certified health professional acting within the scope of the health professional's license or certification who does not perform a Telemedicine medical service that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including:

1. Compressed digital interactive video, audio, or data transmission;
2. Clinical data transmission using computer imaging by way of still-image capture and store and forward; and
3. Other technology that facilitates access to health care services or medical specialty expertise.

TELEMEDICINE means professional services given a Covered Person through an interactive telecommunication system by a Provider at a distant site.

URGENT CARE means Covered Services rendered at an Urgent Care Facility which are appropriate to the treatment of an Injury or Sickness that is not an Emergency Medical Condition, but requires prompt medical attention. Urgent Care includes the treatment of minor Injuries as a result of Accidents, the relief or elimination of acute pain, or the moderation of an acute Sickness.

USUAL AND CUSTOMARY CHARGE means the lesser of:

1. A Provider's usual Charge for furnishing treatment, service or a supply; or
2. The charge the Company determines to be the general rate charged by others who render or furnish such treatment, services or supplies to persons who reside in the same area and whose Injury or Sickness is comparable in nature and severity.

WE, OUR, US AND COMPANY mean UnitedHealthcare Insurance Company.

YOU AND YOUR mean the Insured Person.

General Provisions

CERTIFICATE. Each Covered Person will receive individual Certificates and a Schedule of Benefits. The Certificate and Schedule of Benefits summarize the benefits provided by the Policy. If there is a conflict between the Policy and the Certificate, the Policy will control.

CLERICAL ERROR. Clerical error does not invalidate insurance otherwise validly in force, nor continue insurance otherwise validly terminated. Neither the passage of time nor the payment of premiums for a person who is not eligible for insurance under the terms of the Policy makes this insurance valid for such person. In this event, the Company's only liability is the proper refund of unearned premiums. If a premium adjustment requires the refund of unearned premium, the maximum refund is the six (6)-month period preceding the date the Company receives proof of the adjustment. The Company can request such information while the Policy is in force and for one (1) year after the Policy ends.

CONFORMITY TO STATE AND FEDERAL LAW. The Company amends any provision of the Policy that conflicts with state or federal law on the Policy Effective Date to the minimum requirements of the law.

GROUP POLICYHOLDER NOT OUR AGENT. The Group Policyholder is not an agent of the Company.

PROVIDER AS INDEPENDENT AGENT. The Company does not undertake to directly furnish any health care service under the Policy. The obligations of the Company under the Policy are limited to the payment for health care service provided to Covered Persons by Providers who are independent agents.

MEDICAL RECORDS. The Company shall have access to medical and treatment records of Covered Persons to determine benefits, process Claims, utilization review, quality assurance, financial audit, or for any other purpose reasonably related to the Policy benefits. Each Covered Person shall complete and submit to the Company such additional consents, releases and other documents as may be requested by the Company in order to determine or provide benefits under the Policy. The Company reserves the right to reject or suspend a Claim based on lack of supporting medical information or records.

RECOVERY OF PAYMENTS. The Company reserves the right to deduct from any benefits properly payable under the Policy the amount of any payment which has been made:

1. In error;
2. Pursuant to a misstatement contained in a Claim;
3. Pursuant to a misstatement made to obtain coverage under the Policy within two (2) years after the date such coverage commences;
4. With respect to an ineligible person; or
5. Pursuant to a Claim for which benefits are recoverable under any policy or act of law provided for coverage for occupational injury or disease to the extent that such benefits are recoverable. This provision shall not be deemed to require the Company to pay benefits under the Policy in any such instance.

Such deduction may be made against any Claim for benefits under the Policy by a Covered Person if such payment is made with respect to such Covered Person.

DISCHARGE OF LIABILITY. Any payment made in accordance with the provisions of the Policy shall fully discharge the liability of the Company to the extent of such payment.

RIGHT TO RECEIVE INFORMATION. The Group Policyholder shall provide the Company with the information necessary to administer coverage under the Policy. Payroll and any other records of an Insured Person relating to coverage under the Policy shall be open for review by the Company at any reasonable time. The Company may request that information needed to compute the premium be furnished at least once each year.

TIME EFFECTIVE. Whenever an Effective Date of coverage or termination date of coverage is specified by the Policy, such commencement of coverage will be effective as of 12:00 a.m. of that date.

WAIVER OF RIGHTS. The Company's failure to enforce any provision of the Policy does not affect Our right to enforce any provision at a later date, and does not affect the Company's right to enforce any other provision of the Policy.

NOTE: This Certificate constitutes only a summary of the benefits available under the Employer's plan. The Policy between the Company and the Group Policyholder must be consulted to determine the exact terms and conditions of coverage. A copy of the Policy will be furnished upon request and is available at UnitedHealthcare Insurance Company and your Employer's personnel office.

UNITEDHEALTHCARE INSURANCE COMPANY
[450 Columbus Blvd.
Hartford, CT 06115-0450]

Schedule of Benefits
[Secure Horizons][Senior Supplement][Senior Security][UnitedHealthcare][Retiree Benefit][Plan]

[Group: ABC Company]
[Policy Number: XXXXXX]
[Original Effective Date of Policy: XXXXXX]

The Schedule of Benefits is a summary of any Deductibles, Coinsurance and other limits when You receive Covered Services and, with the Certificate, describes your coverage under the Policy. Please refer to **Section One: Your Medical Benefits** in Your Certificate for a more complete explanation of the specific services covered by the Policy. All Covered Services are subject to any Deductible, Coinsurance, [Out-of-Pocket Expense Maximum(s),] conditions, exclusions, limitations, terms and provisions of the Certificate, including any attachment or riders.

The benefits described in the Certificate are based on the assumption that Covered Persons are enrolled in Medicare Part A and Part B. For any Covered Expense that is a Medicare Eligible Expense, the amount payable by the company will be based upon that portion of the Covered Expenses that Medicare does not pay under Medicare Part A and Part B, subject to the conditions, exclusions, limitations, terms and provisions of the Certificate, including any attachments or riders. Covered Persons must use Medicare participating Providers, approved Facilities and approved Hospice agencies.

LIFETIME POLICY MAXIMUM: [None][$40,000-$5,000,000][Unlimited]

DEDUCTIBLES, COINSURANCE MAXIMUMS	PLAN PAYS	YOU PAY
[Calendar] [Plan] Year Deductible		
[Individual] [When a Covered Person reaches the Individual maximum Deductible for the [Calendar][Plan] Year, then the Deductible will be considered satisfied for the remainder of that [Calendar][Plan] Year.]	-0-	[None] [$100-$5,000] [Calendar] [Plan] [Year Deductible] [(with Deductible carried over when paid in the last [1-6] months of the year)]
[Family Maximum] [2 x Individual] [When Covered Expenses for family members accrue to the amount indicated, no additional [Calendar][Plan] Year Deductible will apply to the other family members for the rest of that [Calendar][Plan] Year.]	0-	[None] [$200-$10,000]
[Coinsurance Maximum] [Out-of-Pocket Expense Maximum]		
[Individual] [When a Covered Person reaches the [Coinsurance Maximum][Out-of-Pocket Expense Maximum] for the [Calendar][Plan] Year, Covered Expenses will be paid at [100%] for the remainder of that [Calendar][Plan] Year.]	-0-	[None] [$250-$10,000]
[Family Maximum] [2 x Individual] [When Covered Persons have fully satisfied the [Coinsurance Maximum][Out-of-Pocket Expense Maximum] for the [Calendar][Plan] Year, Covered Expenses will be paid at [100%] for the remainder of that [Calendar][Plan] Year for all Covered Persons in your family.]	-0-	[$500-$20,000]

[Emergency and Urgent Care Services Copayment (per visit)		YOU PAY
Emergency Services Urgent Care Services After satisfaction of the Copayment, benefits will be paid the same as for All Other Outpatient Benefits	-0-	[[$0-$200] Copayment] [Waived if Admitted] [[$0-$200] Copayment] [Waived if Admitted]]
INPATIENT BENEFITS	PLAN PAYS	YOU PAY
Medicare Part A Deductible	[0%-100%]	[0%-100%]
Inpatient Hospital Services [Days 1-60]	[[50%-100%] of Medicare Part A Deductible] [[$0-$2000] Copayment] [per [Admit][Day]]	[Balance] [$0]
[Days 61-90]	[[50%-100%] Coinsurance] [[$0-$2000] Copayment] [per [Admit][Day]]	[Balance] [$0]
[Days 91-150 (While using 60 lifetime reserve days)]	[[50%-100%] Coinsurance] [[$0-$2000] Copayment] [per [Admit][Day]]	[Balance] [$0]
[Additional Days (After 60 lifetime reserve days are used – additional 365 lifetime additional days) beyond 365 lifetime additional days] [Note: Failure to comply with Preauthorization requirements may result in a [$50-$500] [25%-75%] reduction in benefits per admission.]	[[50%-100%] Coinsurance] [[$0-$2000] Copayment] [per [Admit][Day]] [Not Covered]	[Balance] [$0]

Inpatient Mental Health [Note: Failure to comply with Preauthorization requirements may result in a [$50-$500] [25%-75%] reduction in benefits per admission.]	Same as Inpatient Hospital above	[Balance] [$0]
Skilled Nursing Facility (SNF) [Days 1-20] [Days 21-100] [Days 101-365] [Beyond 365 Days] [Note: Failure to comply with Preauthorization requirements may result in a [$50-$500] [25%-75%] reduction in benefits per admission.]	[Not Covered] [[50%-100%] Coinsurance] [Up to [$50-$1000 per day] [[50%-100%] Coinsurance] [Up to [$50-$1000 per day] [Not Covered] [[50%-100%] Coinsurance] [Up to [$50-$1000 per day] [Not Covered] [[50%-100%] Coinsurance] [Up to [$50-$1000 per day] [Not Covered]	[Balance] [Balance] [$0] [Balance] [$0] [Balance] [$0] [Balance] [$0]
[SNF - prior hospital stay requirement waived] [Yes][No]		
Blood and Blood Products Blood (First three pints covered) - [Yes] [No]	[[50%-100%] Coinsurance]	[Balance] [$0]
Hospice Services [Respite Care]	[[50%-100%] Coinsurance] [Balance] [$0] [[50%-100%] Coinsurance] [Balance] [$0]	[Balance] [$0] [Balance] [$0]

[Private Duty Nursing Services]	[[50%-100%] Coinsurance [up to a maximum of] [$50-$500] [per day] [10-100 visits per [Calendar][Plan] Year]	[Balance] [$0]
All Other Inpatient Services Billed by Hospital or Facility	Same as Inpatient Hospital above	[Balance] [$0]
OUTPATIENT & PART B BENEFITS	PLAN PAYS	YOU PAY
Medicare Part B Deductible	[0%-100%]	[0%-100%]
[Medicare Part B Excess Charges]	[0%-100%]	[0%-100%]
Alcohol, Drug or other Substance Abuse	[[$0-$200] Copayment] [per visit]] [[50%-100%] Coinsurance]]	[Balance] [$0]
Blood and Blood Products Blood (First three pints covered) - [Yes] [No]	[[50%-100%] Coinsurance]	[Balance] [$0]
Durable Medical Equipment [Note: Failure to comply with Preauthorization requirements may result in a [$50-$500] [25%-75%] reduction in benefits.]	[[$50-$200] Copayment] [[50%-100%] Coinsurance]	[Balance] [$0]
Home Health Care (for expenses covered by Medicare)	Balance	$0
Hospice – Medicare Part B [Note: Failure to comply with Preauthorization requirements may result in a [$50-$500] [25%-75%] reduction in benefits.]	Balance	$0
[Infusion Therapy] [Note: Failure to comply with Preauthorization requirements may result in a [$50-$500] [25%-75%] reduction in benefits.]	[[$0-$200] Copayment] [[50%-100%] Coinsurance]	[Balance] [$0]
Outpatient Mental Health Care	[[$0-$200] Copayment [per visit] [[50%-100%] Coinsurance]	[Balance] [$0]

[Outpatient Rx Drugs Covered by Medicare (Medicare Part B Drugs Only) [Oral Chemo] [Anti-Emetics] [Antigens]]	[[$0-$200] Copayment] [[50%-100%] Coinsurance]	[Balance] [$0]
[[Outpatient Injectables (Medicare Part B Drugs Only) [Home Health] [Office-Based] [Self Administered]] [Note: Failure to comply with Preauthorization requirements may result in a [$50-$500] [25%-75%] reduction in benefits.]	[[$0-$200] Copayment] [[50%-100%] Coinsurance]	[Balance] [$0]
Periodic Health Screenings (Please Refer to Your Certificate)	[Covered in Full] [[$0-$200] Copayment per visit] [[50%-100% Coinsurance]	[Balance] [$0]
Physician Services	[[50%-100%] Coinsurance] [[$0-$200] Copayment] [per visit]	[Balance] [$0]
[Private Duty Nursing Services]	[[50%-100%] Coinsurance [up to a maximum of] [$50-$500] [per day] [10-100 visits per [Calendar] [Plan] Year]	[Balance] [$0]
All Other Outpatient Benefits	[[$0-$200] Copayment] [[50%-100%] Coinsurance]	[Balance] [$0]
ADDITIONAL BENEFITS	PLAN PAYS	YOU PAY
[Foreign Travel Benefit]	[Covered in Full] [[$0-$500] Deductible] [per] [Calendar] [Plan] Year] [[50%-100%] Coinsurance] [up to a maximum benefit of [$100-$100,000] per [Calendar] [Plan] [Year] [lifetime]	[$0-$500 Deductible] [per] [Calendar] [Plan] Year] [Balance] [$0]
[Home Health Care Not Covered by Medicare] [Note: Failure to comply with Preauthorization requirements may result in a [$50-$500] [25%-75%] reduction in	[[$0-$200] Copayment per visit] [up to a maximum of [10-100] visits per [Calendar] [Plan] Year]] [[50%-100% Coinsurance] [up to a maximum benefit of [$100-$15,000] per [Calendar] [Plan]	[Balance] [$0]

benefits.]	Year]]	
[Periodic Health Screenings Not Covered by Medicare]	[Covered in Full] [[$0-$200] Copayment per visit] [[50%-100% Coinsurance] [up to a maximum benefit of [$0-$1000]]	[Balance] [$0]

THIS POLICY HAS CERTAIN BENEFIT MAXIMUMS. PLEASE REVIEW THIS INFORMATION CAREFULLY SO YOU WILL UNDERSTAND YOUR BENEFITS UNDER THIS PLAN.

NOTE: For Covered Services which are not Medicare Eligible Expenses, Covered Expenses will be paid in accordance with the Usual and Customary Charge criteria as defined in the Certificate.

[Preauthorization is required prior to obtaining certain benefits. [Failure to Preauthorize services will result in a reduction in the benefits payable for Covered Expenses under the Policy.] The Company will conduct a retroactive review to determine the Medical Necessity of the service, and services deemed not Medically Necessary will not be eligible for benefits under the Policy. Additional out-of-pocket expenses incurred by You for not Preauthorizing services will not apply toward Your [Calendar][Plan] Year Deductible or Coinsurance Maximum. To avoid any penalty, please refer to "Preauthorization Requirements."]

[Deductible Carry-Over. Covered Expense applied to a Covered Person's [Calendar][Plan] Year Deductible during the last [one-six 1-6] months of a [Calendar][Plan] Year will apply to that Covered Person's [Calendar][Plan] Year Deductible for the following [Calendar][Plan] Year.]

[Deductible Takeover. If the Policy is replacing a similar Policy that had been issued to the Group Policyholder, any portion of any Deductible the Covered Person had satisfied under the replaced plan shall apply to the satisfaction of the Covered Person's initial [Calendar][Plan] Year Deductible under the Policy. Proof of Deductible satisfaction under the replaced plan will be required upon submission of the initial Claim for benefits to be payable under the Policy.]

UNITEDHEALTHCARE INSURANCE COMPANY
(the "Company")
[450 Columbus Blvd.
P.O.Box 150450
Hartford, CT 06115-0450]

[SECURE HORIZONS]
[SENIOR SUPPLEMENT][SENIOR SECURITY]
[UNITEDHEALTHCARE][RETIREE BENEFIT] [PLAN]

Hearing Care Benefit Rider

UnitedHealthcare Insurance Company
(Herein called We, Our, Us and the Company)
[450 Columbus Blvd.]
[Hartford, CT 06115-0450]

This Rider is issued as part of the Policy and any Certificate to which it is attached. This Rider is subject to all the terms and provisions of the Policy, except as stated below. In consideration of any additional Premium, We will provide the coverage described in this Rider.

BENEFITS

The Company will pay a Hearing Care Benefit for Covered Expenses incurred by a Covered Person for Covered Services described in the Hearing Care Schedule of Benefits, subject to the Exclusions and Limitations described in this Rider, which do not exceed any applicable maximum shown in the Certificate of this Rider.

Hearing Care Schedule of Benefits. Benefits will not exceed the limits set forth below:

Hearing Care Schedule of Benefits	
[Hearing Aid[s]	Limited to [1-2] Hearing Aid[s] per [Calendar][Plan] Year]
[Hearing Aid[s] Maximum Benefit: [[$500–$5,000] per [Plan Year] [Calendar Year]] [[$500-$5000] per [12-36] month period]]	

COVERED SERVICES

Covered Services are limited to those services that are:

1. for the care of a Hearing Impairment or loss; and
2. provided by a Physician, or licensed or certified therapist.

HEARING CARE BENEFIT MAXIMUM

The Hearing Care Benefit Maximum per Covered Person for all Covered Expenses is the amount shown in the Hearing Care Benefit Schedule of Benefits. It applies separately to each Covered Person.

DEFINITIONS

[**Calendar Year** means January 1, 12:00 a.m. to December 31, 11:59 p.m. of the same year.]

[**Hearing Aid** means an electronic amplifying device designed to bring sound more effectively into the Covered Person's ear. A Hearing Aid consists of a microphone, amplifier, and receiver.]

[**Hearing Impairment** means a reduction in the ability to perceive sound and may range from slight to complete deafness.]

[**Plan Year** means any consecutive 12 month period beginning on the Effective Date shown in the Policy.]

EXCLUSIONS AND LIMITATIONS

Hearing Care Benefits are not payable for expenses excluded by the Certificate, unless provided for in this Benefit Rider, and for the following:

1. Care or treatment for a Hearing Impairment due to a functional nervous disorder;
2. Services or supplies covered in whole or in part under any other portion of the Policy or under any other medical expense benefits for hearing benefits provided by the Employer;
3. Medical or surgical treatment of Hearing Impairment;
4. Outpatient Prescription Drugs, or other medications to treat Hearing Impairment;
5. Any treatment or services caused by or arising out of the course of employment, or covered under any public liability insurance, including but not limited to Workers' Compensation programs;
6. [Hearing Aids] prescribed by a Physician prior to the Covered Person's Effective Date under the Policy, or after the Covered Person's termination of coverage under the Policy;
7. [Hearing Aids prescribed by a Physician while the Covered Person is covered under the Policy, but delivered to the Covered Person more than thirty (30) days after the Covered Person's termination of coverage under the Policy;]
8. [Hearing Aids] for which the Covered Person is not obligated to pay, or for which no charge would be made in the absence of [Hearing Aid] coverage under the Policy;
9. [Hearing Aids] which are not Medically Necessary or not prescribed by a Physician;
10. [Hearing Aids] that do not meet professionally accepted standards or practice, including [Hearing Aids] which are for Experimental and/or Investigational treatment;
11. [Hearing Aids] provided by any governmental agency or that are obtained by the Covered Person without cost;
12. [Replacement of Hearing Aids that are lost, broken or stolen unless, at the time of such replacement, the Covered Person is otherwise eligible for a hearing aid benefit under the Policy;]
13. [Replacement parts for Hearing Aids and repair of Hearing Aids;]
14. Charges for the completion of any benefit request forms.

Payment of Hearing Care Benefits is subject to all of the terms of the Policy that are not inconsistent with these provisions, including, but not limited to, the Policy Exclusions and Limitations.

EFFECTIVE DATE

This Rider is effective on the Effective Date of the Group Health Insurance Policy and Certificate to which it is attached, and is subject to all the provisions, definitions, limitations and conditions of the Policy and Certificate. This Rider terminates at the same time as the Group Health Insurance Policy and Certificate. This Rider does not change, waive or extend any part of the Policy and Certificate other than as stated herein.

Signed on behalf of UnitedHealthcare Insurance Company

[Allen J. Sorbo]
President

Notes

Underwritten by UnitedHealthcare Insurance Company

Customer Service

[1-800-XXX-XXXX]
[(or for the hearing impaired, 1-800-XXX-XXXX)]
[7 a.m. to 7 p.m.] [Local Time] [PT] [MT] [ET] [CT]
[Monday through Friday]

[Visit our Web site at *www.XXXXXXXX*@uhc.com]

UNITEDHEALTHCARE INSURANCE COMPANY
(the "Company")
[450 Columbus Blvd.
P.O.Box 150450
Hartford, CT 06115-0450]

[SECURE HORIZONS]
[SENIOR SUPPLEMENT][SENIOR SECURITY]
[UNITEDHEALTHCARE][RETIREE BENEFIT] [PLAN]

Vision Care Benefit Rider

UnitedHealthcare Insurance Company
(Herein called We, Our, Us and the Company)
[450 Columbus Blvd.]
[Hartford, CT 06115-0450]

This Rider is issued as part of the Policy and any Certificate to which it is attached. This Rider is subject to all the terms and provisions of the Policy, except as stated below. In consideration of any additional Premium, We will provide the coverage described in this Rider.

BENEFITS

The Company will pay a Vision Care Benefit for Covered Expenses incurred by a Covered Person for Covered Services described in the Vision Care Schedule of Benefits, subject to the Exclusions and Limitations described in this Rider, which do not exceed any applicable maximum shown in the Certificate of this Rider.

Vision Care Schedule of Benefits. Benefits will not exceed the limits set forth below:

Vision Care Schedule of Benefits	
[Eye Examination for eyeglasses or contact lenses (refraction): Benefits limited to [1-2] eye examination[s] [per] [every] [Plan Year][Calendar Year] [[12-36]month period]]	[Copayment][Percentage Payable]: [50%–100%] [$0–$50] [per visit]
[Lenses and frames or contact lenses: Benefits limited to [1-2] pair of lenses and frames or contact lenses per [Calendar Year][Plan Year], [but not both] [[12-36] month period]]	[Copayment][Percentage Payable]: [50%–100%] [$0–$50] [per visit]
[Eye Examination Maximum Benefit: [[$50-$500] every [12-36] [Month Period] [Plan Year][Calendar Year]] [[$25–$100] per visit]] [Eyewear Maximum Benefit: [[$500–$5,000] per [Plan Year] [Calendar Year]]	

COVERED SERVICES

Covered Services are limited to those Vision Care services which are provided by a Physician, an Optometrist or Optician for [an eye examination] [and/or] [Eyewear] to the Covered Person.

VISION CARE BENEFIT MAXIMUM

The Vision Care Benefit Maximum per Covered Person for all Covered Expenses is the amount shown in the Vision Care Benefit Schedule of Benefits. It applies separately to each Covered Person.

DEFINITIONS

[Calendar Year means January 1, 12:00 a.m. to December 31, 11:59 p.m. of the same year.]

[Eyewear means frames, single vision, bifocal, trifocal, and lenticular lenses and contact lenses.]

[Plan Year means any consecutive 12 month period beginning on the Effective Date shown in the Policy.]

[Vision Care means those services prescribed by a Physician, an Optometrist or Optician for the care and treatment of the Covered Person's vision.]

EXCLUSIONS AND LIMITATIONS

Vision Care Benefits are not payable for expenses excluded by the Certificate, unless provided for in this Benefit Rider, and for the following:

1. Medical or surgical treatment of the eye;
2. Outpatient Prescription Drugs or other medications for the eyes;
3. Experimental and/or Investigational treatment;
4. Care or treatment for any Sickness or Injury arising out of or in the course of employment, or for which benefits are payable under any Workers' compensation Act or similar legislation, or services provided by a government agency;
5. Charges for completion of insurance or other claim forms, or charges for missed or rescheduled appointments;
6. [Eye examinations;]
7. [Lenses which do not require a prescription written by a Physician, including eyeglasses or lenses which provide no visual correction or are for cosmetic use;]
8. [All lenses, frames, eyeglasses, contact lenses whether or not they require a prescription;]
9. [Duplicate eyeglass lenses or frames;]
10. [Two (2) pairs of eyeglasses in lieu of bifocals; three (3) pairs of eyeglasses in lieu of trifocals].

EFFECTIVE DATE

This Rider is effective on the Effective Date of the Group Health Insurance Policy and Certificate to which it is attached, and is subject to all the provisions, definitions, limitations and conditions of the Policy and Certificate. This Rider terminates at the same time as the Group Health Insurance Policy and Certificate. This Rider does not change, waive or extend any part of the Policy and Certificate other than as stated herein.

Signed on behalf of UnitedHealthcare Insurance Company

[Allen J. Sorbo]
President

Notes

Underwritten by UnitedHealthcare Insurance Company

Customer Service

[1-800-XXX-XXXX]
[(or for the hearing impaired, 1-800-XXX-XXXX)]
[7 a.m. to 7 p.m.] [Local Time] [PT] [MT] [ET] [CT]
[Monday through Friday]

[Visit our Web site at *www.XXXXXXXX*@uhc.com]

UNITEDHEALTHCARE INSURANCE COMPANY
(the "Company")
[450 Columbus Blvd.
P.O.Box 150450
Hartford, CT 06115-0450]

[SECURE HORIZONS]
[SENIOR SUPPLEMENT][SENIOR SECURITY]
[UNITEDHEALTHCARE][RETIREE BENEFIT] [PLAN]

Neuromuscular Skeletal Disorders Benefit Rider

UnitedHealthcare Insurance Company
(Herein called We, Our, Us and the Company)
[450 Columbus Blvd.]
[Hartford, CT 06115-0450]

This Rider is issued as part of the Policy and any Certificate to which it is attached. This Rider is subject to all the terms and provisions of the Policy, except as stated below. In consideration of any additional Premium, We will provide the coverage described in this Rider.

BENEFITS

Covered Services will include the treatment of Neuromuscular Skeletal Disorders. Treatment may include, but is not limited to: the therapeutic use of heat; cold; exercise; electricity; ultraviolet radiation; manipulation of the spine or massage for the purpose of improving circulation; strengthening muscles; or encouraging the return of motion.

Neuromuscular Skeletal Disorders Schedule of Benefits. Benefits will not exceed the limits set forth below:

Neuromuscular Skeletal Disorder Benefit	
Office Visits: Limited to [[12–30] visits per] [Calendar Year] [Plan Year]	[Copayment][Percentage Payable]: [50%–100%] [$0–$50] [per visit]
Maximum Benefit: [[$25–$100] per visit] [[$500–$5,000] per Plan Year] [[$500–$5,000] per Calendar Year]	

COVERED SERVICES

The treatment will be considered Covered Services only if:

1. the treatment is performed by an individual who is licensed or registered to perform such therapy; and
2. any medical appliance or equipment that is required for the treatment has been prescribed by a Physician.

NEUROMUSCULAR SKELETAL DISORDER BENEFIT MAXIMUM

The Neuromuscular Skeletal Disorder Benefit Maximum per Covered Person for all Covered Expenses is the amount shown in the Neuromuscular Skeletal Disorder Schedule of Benefits. It applies separately to each Covered Person.

DEFINITIONS

[Calendar Year means January 1, 12:00 a.m. to December 31, 11:59 p.m. of the same year.]

[Neuromuscular Skeletal Disorders means misalignment of skeletal structures and muscular weaknesses, imbalance, and disorders related to the spinal cord, neck and joints.]

[Plan Year means any consecutive 12 month period beginning on the Effective Date shown in the Policy.]

EXCLUSIONS AND LIMITATIONS

No benefits will be provided for, or in connection with, the following treatments, services or supplies:

1. Services for examination and/or treatment of strictly non-Neuromuscular-Skeletal Disorders;
2. Services or treatments not documented as clinically necessary and appropriate or classified as Experimental or Investigational;
3. Diagnostic Scanning, including Magnetic Resonance Imaging (MRI), CAT Scans, and/or other types of diagnostic scanning such as Thermography;
4. Treatment of services for pre-employment physicals or vocational rehabilitation;
5. Any treatment or services caused by or arising out of the course of employment, or covered under any public liability insurance, including but not limited to Workers' Compensation programs;
6. Hypnotherapy, behavior training, sleep therapy and weight programs, educational programs, non-medical self-care or self-help physical exercise training or any related diagnostic testing;
7. Vitamins, minerals, nutritional supplements or other similar-type products;
8. Manipulation under Anesthesia, Hospitalization or any related services;
9. Air conditioners, air purifiers, therapeutic mattress supplies or any other similar device or appliance; and
10. X-rays taken to demonstrate misalignment.

Effective Date

This Rider is effective on the Effective Date of the Group Health Insurance Policy and Certificate to which it is attached, and is subject to all the provisions, definitions, limitations and conditions of the Policy and Certificate. This Rider terminates at the same time as the Group Health Insurance Policy and Certificate. This Rider does not change, waive or extend any part of the Policy and Certificate other than as stated herein.

Signed on behalf of UnitedHealthcare Insurance Company

[Allen J. Sorbo]
President

Notes

Underwritten by UnitedHealthcare Insurance Company

Customer Service

[1-800-XXX-XXXX]
[(or for the hearing impaired, 1-800-XXX-XXXX)]
[7 a.m. to 7 p.m.] [Local Time] [PT] [MT] [ET] [CT]
[Monday through Friday]

[Visit our Web site at *www.XXXXXXXX*@uhc.com]

UNITEDHEALTHCARE INSURANCE COMPANY
(the "Company")
[450 Columbus Blvd.
P.O.Box 150450
Hartford, CT 06115-0450]

[SECURE HORIZONS]
[SENIOR SUPPLEMENT][SENIOR SECURITY]
[UNITEDHEALTHCARE][RETIREE BENEFIT] [PLAN]

Outpatient [Formulary] Prescription Drug Benefit Rider

UnitedHealthcare Insurance Company
(Herein called We, Our, Us and the Company)
[450 Columbus Blvd.]
[Hartford, CT 06115-0450]

This Rider is issued as part of the Policy and any Certificate to which it is attached. This Rider is subject to all the terms and provisions of the Policy, except as stated below. In consideration of any additional Premium, We will provide the coverage described in this Rider.

BENEFITS

The Company will pay an Outpatient Prescription Drug Benefit for Covered Expense incurred by a Covered Person for Covered Services described in this Rider. The benefit will be subject to the [[Calendar] [Plan] Year Deductible,] [Copayments] [Coinsurance] and Exclusions and Limitations described in this Rider, and will not exceed any applicable Maximum shown in the Certificate or this Rider.

OUTPATIENT PRESCRIPTION DRUG SCHEDULE OF BENEFITS

Benefits will be paid at the Percentage Payable set forth in the Schedule of Benefits. [For Non-Formulary drugs, the Covered Person must obtain Pre-Authorization to receive any benefits.]

Copayment amount for a [30 day supply] [Unit supply] per [Formulary] prescription:

Outpatient Prescription Drug Schedule of Benefits		
[Participating Provider Pharmacy]	[Non-Participating Provider Pharmacy]	[Mail Service 90-Day Supply]
[[$0 - $5,000] [Calendar] [Plan] Year Deductible [Combines] Retail [and Mail Service] [[5% - 50%] Coinsurance] [[50% - 100%] after Copayment of:] [[$0 - $50] Generic [Formulary]] [[$0 - $50] Brand Name [Formulary]] [[$0 - $75] Non-Formulary]] [per [Unit] [30-day] supply]]	[[$0 - $5,000] [Calendar] [Plan] Year Deductible [Combines] Retail [and Mail Service] [[5% - 50%] Coinsurance] [[50% - 100%] after Copayment of:] [[$0 - $50] Generic [Formulary]] [[$0 - $50] Brand Name [Formulary]] [[$0 - $75] Non-Formulary]] [per [Unit] [30-day] supply] [Not Covered]]	[[$0 - $5,000] [Calendar] [Plan] Year Deductible [Combines] Retail [and Mail Service] [[5% - 50%] Coinsurance] [[50% - 100%] after Copayment of:] [[$0 - $50] Generic [Formulary]] [[$0 - $50] Brand Name [Formulary]] [[$0 - $75] Non-Formulary]] [per Mail Service Unit or 90-day supply] [Not Covered]]

[Annual] [Calendar] [Plan] [Year] [Lifetime] Maximum benefit for [combined] [Generic] [and] [Brand Name] drug for [both] [Retail] [and] [Mail Service]: [$500 – Unlimited] [not to exceed the Policy Maximum]

[For Brand name drugs which have Generic equivalents, the Covered Person pays the Generic drug plan Copayment plus the difference between the cost of the Generic drug and the Brand Name drug.]

[Brand Name drugs which have Generic equivalents are considered Non-Formulary and the Covered Person pays the Non-Formulary Copayment]

DEFINITIONS

[[Calendar] [Plan] Year Deductible means the amount of Covered Expenses shown on the Schedule of Benefits that a Covered Person is responsible for paying each [Calendar] [Plan] Year before benefits are payable for prescription drugs. A Covered Expense that a Covered Person has to pay due to any other plan Deductible or any Copayment will not be applied toward satisfying the prescription drug [Calendar] [Plan] Year Deductible.]

[Calendar Year means January 1, 12:00 a.m. to December 31, 11:59 p.m. of the same year.]

[Formulary means a continually updated list of prescription medications which are approved by the Company. The Formulary contains both brand name drugs and generic drugs, all of which have Food and Drug Administration (FDA) approval.]

[Participating Pharmacy means a pharmacy that has contracted with the Company to provide Outpatient Prescription Drugs to a Covered Person at negotiated costs.]

[Pre-Authorization means the review process whereby the Medical Necessity of a prescription drug is reviewed prior to the Covered Person receiving such prescription drug from a pharmacy.]

[Plan Year means any consecutive 12 month period beginning on the Effective Date shown in the Policy [other than a Calendar Year]].

[Non-Participating Pharmacy means a pharmacy that has not contracted with the Company.]

[Unit means the maximum amount (quantity) of medication that may be dispensed per single Copayment. For most oral medications, a Unit represents a 30-day supply [or 90-day supply (through the mail service benefit)] of medication. For other medications, a Unit represents a single container, inhaler unit, vial, package or course of therapy. [The Unit will be tripled, e.g., 3 containers, 3 inhaler units, etc. if the medication is dispensed through the Mail Service benefit for a 90-day supply.] For drugs that could be habit-forming, a Unit may be set at a smaller quantity for the Covered Person's protection and safety.]

[30-day supply means, for most oral medications, the maximum amount (quantity) of medication that may be dispensed per single [Copayment] [Coinsurance amount] [at any one time].

[90-day supply means, for most oral medication purchased through the mail service benefit, the maximum amount (quantity) of medication that may be dispensed per single Mail Service [Copayment] [Coinsurance amount] [at any one time] [during a 90-day period].

[FORMULARY PRESCRIPTION DRUG BENEFIT

[You or Your Physician may contact the Company at the Customer Service number on Your ID Card [or Our website [www.XXXXXXX@uhc.com]] to determine if a particular drug is part of the Formulary or to obtain a list of Formulary Drugs. Your Physician is not obligated to prescribe a Formulary Drug and may prescribe any FDA approved drug he or she feels is [Medically Necessary] [appropriate] for your treatment. However, prescription for non-Formulary medications which have not received prior authorization from the Company will not be a Covered Expense.]

[If a Formulary drug you are taking is removed from the Formulary list, you may continue to purchase that medication at the Formulary rate shown in the Schedule of Benefits until the next [Policy Anniversary] [renewal] date.]

COVERED EXPENSE

Except as provided for maintenance drugs, purchased through Mail Service, Covered Expense for a Covered Service will not exceed the negotiated cost at a Participating Pharmacy for the lesser of the following:

1. the Unit supply usually prescribed by a Provider; or
2. a 30-day supply.

COVERED SERVICES

Covered Services include Outpatient Prescription Drugs prescribed by a licensed Provider and dispensed by a pharmacy for the treatment of an Injury or Sickness. Covered Services consist only of Medically Necessary drugs and medications which, in accordance with federal or state laws, may not be dispensed without the written prescription of a Provider, or which are dispensed by a Provider who dispenses Outpatient Prescription Drugs to patients when required to do so in the course of his or her regular practice. The Outpatient Prescription Drug Benefit will be provided for the following medications when ordered by a Provider:

1. Federal legend Drugs: any medicinal substances which bear the legend "Caution: Federal law prohibits dispensing without a prescription."
2. State Restricted Drugs: any medicinal substance which may be dispensed by prescription only according to state law.
3. Insulin, insulin syringes, inhaler extender devices, anaphylaxis prevention kits.
4. [Federal Legend oral contraceptives, prescription diaphragms and oral infertility drugs.]

[MAIL SERVICE

Maintenance drugs may be dispensed for up to a [3-month] [90-day] supply through the Mail Service benefit. The Copayment amount is specified in the Schedule of Benefits.]

[PRE-AUTHORIZATION FOR [NON-FORMULARY][SELECTED] DRUGS

[Coverage for selected drugs will require the Company's Pre-authorization. The Pre-authorization review process is to ensure that the selected drugs are Medically Necessary and being utilized according to treatment guidelines consistent with good professional practices. For a list of the selected medications that require the Company's pre-authorization, please contact the Customer Service Department at the number listed on Your ID Card.]

[If a non-Formulary prescription is recommended, it will not be covered unless the non-Formulary drug is Pre-authorized. Pre-authorization requests must be initiated by the Covered Person's Physician. Non-Formulary drugs, which are not otherwise excluded from coverage, will be Pre-authorized in the following instances:

1. No Formulary alternative is appropriate and it is determined that the drug is Medically Necessary;
2. The Formulary alternative has failed after therapeutic trial. The Covered Person's Physician will be asked to provide a copy of the medical chart notes specifically stating treatment failure with the Formulary alternative;
3. The Formulary alternative is not appropriate as determined by review of Physician chart notes;
4. The Covered Person has been under treatment and remains stable on a non-Formulary prescription drug and conversion to a Formulary drug would be medically inappropriate;
5. The Covered Person has experienced typical allergic reaction or established adverse effects relating to the pharmacological properties of the Formulary drug which are attributed to formulations or differences in absorption, distribution or elimination; or
6. The Covered Person's Physician provides evidence to the Company in the form of documents, records or clinical trials which establishes that the use of the requested non-Formulary drug over the Formulary drug is Medically Necessary.]]

EXCLUSIONS AND LIMITATIONS

No benefits are payable for any of the following:

[1. Drugs or medicines purchased and received prior to the Covered Person's effective date or subsequent to the Covered Person's termination.]
[2. Therapeutic devices or appliances, even though they may require a prescription. This includes: hypodermic needles; syringes (except insulin syringes when provided by a Participating Pharmacy for use with approved self-injectable medications); support garments; and other non-medical substances.]
[3. All non-prescription contraceptive jellies, ointments, foams or devices.]
[4. Drugs dispensed by a Hospital, rest home, sanitarium, Skilled Nursing Facility, convalescent care facility, nursing home or similar institution while confined as a patient.]
[5. Drugs or medicines delivered or administered to the Covered Person by the Provider or the Provider's staff.]
[6. Dietary supplements, including vitamins and fluoride supplements (except prenatal0, health or beauty aids and diet pills, and dental related products, such as topical fluoride, medicated dental rinses and children's fluoride vitamins.]
[7. Medication which may be properly received without charge under local, state, or federal programs or which is reimbursable under other insurance programs including Workers' Compensation and Medicare.]
[8. Medications prescribed for experimental or non-FDA approved indications unless prescribed in a manner consistent with a specific indication in Drug Information for the Health Care Professional, published by the United States Pharmacopeial Convention or in the American Hospital Formulary Services edition of Drug Information; medications limited to investigational use by law.]
[9. For patent drugs or medications available without a prescription (over the counter) or for which there is a non-prescription equivalent available.]
[10. Drugs or medicines used or taken primarily to improve or otherwise modify the Covered Person's external appearance.]
[11. Smoking cessation products including, but not limited to, nicotine gum, nicotine patches, or any other drug containing nicotine or other smoking deterrent medications.]
[12. Administration or injection of any drug.]
[13. Immunizing agents, injectables (except insulin), biological sera, blood plasma or medication prescribed for parenteral use.]
[14. Any applicable sales tax or surcharge.]
[15. Outpatient prescription drugs determined not to be effective for the specific diagnosis or which do not follow community practice standards.]
[16. Injectable infertility drugs.]
[17. Federal Legend oral contraceptives, prescription diaphragms and oral infertility drugs.]
[18. Prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence and anorgasmy or hyporgasmy.]
[19. Elective or voluntary enhancement procedures, services, supplies and medications including, but limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance.]
[20. New prescription medications or supplies until they are reviewed for safety, efficacy and cost effectiveness, and approved by the Company.]
[21. Compound Medication: any medicinal substance which has at least one ingredient that is Federal Legend or State Restricted in a therapeutic amount.]
[22. Drugs prescribed by a dentist or Drugs used for dental treatment.]
[23. Drugs used for diagnostic purposes.]
[24. Saline and irrigation solutions.]
[25. Replacement of lost, stolen or destroyed medications.]
[26. Unit dose/convenience dosage forms: Unit dose, pre-packaged medications, individual packets, etc.]
[27. Weight loss medication: Services to treat obesity (excessive weight), including, but not limited to, prescription or non-prescription weight loss medications, weight control programs, supplies or supplements are not covered.]]

Any benefit provided under the outpatient Prescription Drug Benefit is not eligible as a Covered Expense under any other provision of the Policy.

[NON-PARTICIPATING PHARMACY REIMBURSEMENT/DIRECT REIMBURSEMENT

For prescriptions obtained at a Non-Participating Pharmacy or when submitting a claim for direct reimbursement, the Covered Person must complete a claim form and submit a prescription receipt from the pharmacist. The receipt must specify the prescription number, name of drug, date filled, name of pharmacy, name of patient, and proof of payment. The Company will reimburse the Covered Person for the Covered Expense as shown on the Schedule of Benefits.]

[If a Participating Pharmacy is Not Available

The Outpatient Prescription Drug Benefit is honored only at Participating Pharmacies. The Covered Person is eligible for reimbursement only if a Participating Pharmacy is not available or accessible. In this situation, the Covered Person must pay the pharmacy the retail price for the prescription and then file a claim for direct reimbursement. For direct reimbursement, the Covered Person should submit a completed claim form and the pharmacy receipt showing the prescription number, name of drug, date filled, name of pharmacy, name of patient, and proof of payment to:

[XXXXXXXXXXXXXXX]
[P.O. Box XXXX]
[XXXXXXXXX, XX XXXXX]

EFFECTIVE DATE

This Rider is effective on the later of [January 1, 20XX] or the Effective Date of the Group Health Insurance Policy and Certificate to which it is attached, and is subject to all the provisions, definitions, limitations and conditions of the Policy and Certificate. This Rider terminates at the same time as the Group Health Insurance Policy and Certificate. This Rider does not change, waive or extend any part of the Policy and/or Certificate other than as stated herein.

Signed on behalf of UnitedHealthcare Insurance Company

[Allen J. Sorbo]
President

Notes

Underwritten by UnitedHealthcare Insurance Company

Customer Service

[1-800-XXX-XXXX]
[(or for the hearing impaired, 1-800-XXX-XXXX)]
[7 a.m. to 7 p.m.] [Local Time] [PT] [MT] [ET] [CT]
[Monday through Friday]

[Visit our Web site at *www.XXXXXXXX*@uhc.com]

UNITEDHEALTHCARE INSURANCE COMPANY
[450 Columbus Blvd.
Hartford, CT 06115-0450]

CONSUMER INFORMATION NOTICE

Policyholder Service Office of Company: [UnitedHealthcare Insurance Company]
[P.O.Box XXXX]
[XXXXXXX, XX XXXXX]
[-XXX-XXX-XXXX]

If we at UnitedHealthcare Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Department of Insurance
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201-1904
(800) 852-5494
(501) 371-2640

LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
C/o The Liquidation Division
1023 West Capitol
Little Rock, Arkansas 72201
Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC")(whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective

investment trust or similar pooled fund offered by a bank or other financial institution);

- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do ~~not~~ not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $300,000 limit, the Association will not pay more than $300,000 in health insurance benefits, $300,000 in present value of annuity benefits, or $300,000 in life insurance death benefits or net cash surrender values - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

SERFF Tracking Number:	*UHLC-126036498*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41573*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002C Large Group Only - Other*
Product Name:	*2009 UnitedHealthcare Senior Supplement*		
Project Name/Number:	*2009 UnitedHealthcare Senior Supplement /*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*UHLC-126036498*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41573*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002C Large Group Only - Other*
Product Name:	*2009 UnitedHealthcare Senior Supplement*		
Project Name/Number:	*2009 UnitedHealthcare Senior Supplement /*		

Supporting Document Schedules

Review Status:

Satisfied -Name: Flesch Certification — Approved-Closed — 02/20/2009

Comments:

Attached please find the Certification of Readability and the Certification of Unfair Sex Discrimination. The Guaranty Association Notice and the Consumer Information Notice are attached to the Forms tab for your review and approval.

Attachments:

CERTIFICATION OF READABILITY.pdf

CERTIFICATION OF UNFAIR SEX DISCRIMINATION.pdf

Review Status:

Satisfied -Name: Application — Approved-Closed — 02/20/2009

Comments:

Attached please find the Group Application and the Enrollment Form which are to be used with these policy forms.

Attachments:

SRINS-GRP-NA-AR.pdf

SRINS-APP-NA-AR.pdf

Review Status:

Satisfied -Name: Cover Letter — Approved-Closed — 02/20/2009

Comments:

Attached please find the Cover Letter that provides the details for this large group major medical filing.

Attachment:

SUBMISSION LETTER DRAFT.pdf

CERTIFICATION OF READABILITY

Re: UnitedHealthcare Insurance Company
NAIC: #79413, FEIN 35-2739571

I certify that the forms in this filing have been tested under the Flesch methodology and meet the minimum required reading ease score. The combination of forms has a score of 45.

The following language or terminology has been excepted from scoring: Name and address of Insurer; Name, number and title of the form; Table of Contents or Index; Titles, Captions and Sub-captions; schedules or tables; and the following provisions of the form:

Language required by any federal or state law, regulation or agency interpretation: The sections entitled *Payment Responsibility, Covered Person Eligibility, Health Care Decisions or Decisions Regarding Your Benefits*.

Medical terminology: The section entitled *Your Medical Benefits.*

Words defined in the Certificate: The section entitled *Definitions.*

Schedule of Benefits

_____	Vice President Compliance _____
Signature of Authorized Representative	Title of Authorized Representative
Paul D. Kallmeyer	February 17, 2009
Printed Name of Authorized Representative	Date

CERTIFICATION OF UNFAIR SEX DISCRIMINATION

I hereby certify that the form filing submitted on behalf of UnitedHealthcare Insurance Company ("UnitedHealthcare") to be used in connection with Group Health insurance Policy SRINS-POL meets the provisions of Arkansas Rule and Regulation 19, as well as applicable requirements of the Arkansas Insurance Department.

By: _____
Paul D. Kallmeyer

Title: Vice President, Compliance

Underwritten by
UnitedHealthcare Insurance Company

Application for Group Coverage

APPLICATION is hereby made to **UNITEDHEALTHCARE INSURANCE COMPANY** (Herein called "UnitedHealthcare") for group coverage based upon the following statements and representations:

EMPLOYER INFORMATION

Employer's Legal Name	Tax ID Number		
☐ Proprietorship ☐ Partnership ☐ Corporation ☐ Other			
Employer's Address	City	State	ZIP
Executive Contact	Title		
E-mail Address	Fax ( )	Phone ( )	
Benefits Administrator Contact	Title		
Address (if different)	City	State	ZIP
E-mail Address	Fax ( )	Phone ( )	
Name and address of any affiliated or subsidiary firms whose Employees are to be covered			
Industry/Nature of Business (be specific)	SIC Code	Years in Business	
Is this employer group subject to ERISA regulations? ☐Yes ☐ No If no, explain why:			
Is this business currently in Chapter 11 or has the business filed for bankruptcy within the last 12 months? ☐Yes ☐ No			
Proposed Effective Date: / /	Proposed Renewal Date: / /	Open Enrollment Period: / /	
Group Size: Number of Employees: _____ Number of Employees not eligible for group coverage: _____ Number of Retirees: _____ Number of retirees not eligible for group retiree coverage: _____			
Estimated First Monthly Premium $ _____ accompanies this Application (if applicable) Group Policyholder Premium Contribution %: _____			
☐ Senior Supplement Plan _____ ☐ Senior Security Plan _____ *(Note: To be completed by UnitedHealthcare Sales Representative)*			

EMPLOYER STATEMENT

The Employer hereby applies for the insurance coverage indicated (including coverage indicated on any Supplemental Application(s)) and agrees to all of the following:

a. The Employer represents that all the information on this Application, including any Supplemental Application(s) submitted herewith, (collectively, the "Application"), is true and complete, and that UnitedHealthcare may rely on this Application in deciding whether to provide coverage. If the Application is not complete, or if the information provided on the Application is inconsistent with any request for proposal for coverage submitted to UnitedHealthcare, UnitedHealthcare reserves the right to re-rate the premium associated with such coverage, or reject the Application. If this Application is accepted, it becomes part of our Policy with UnitedHealthcare.

b. Any material misstatement or omission of information on this Application, any request for proposal for coverage, or on any enrollment form will be considered a misrepresentation and may be the basis of later termination or rescission of coverage issued on the basis of the submitted information.

c. Employer understands and agrees that no coverage will be effective before the date determined by UnitedHealthcare (the "Effective Date") and only if the Employer has paid the first month's premium and this Application has been received and accepted by UnitedHealthcare.

d. Covered persons are not insured prior to the Effective Date. If proof of insurability is required, insurance is not effective until UnitedHealthcare has approved this proof.

e. No statement, representation or promise shall have any effect unless contained in a document signed by an officer or Underwriting Manager of UnitedHealthcare, either contained in, or attached to, the Application.

f. All statements and descriptions in this application form are deemed to be representations and not warranties.

g. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

EMPLOYER

Officer's Name	Title
Officer's Signature	Date

UNITEDHEALTHCARE REPRESENTATIVE

UnitedHealthcare Representative's Name	Title
UnitedHealthcare Representative's Signature	Date

This is not a Medicare supplement plan. This is an employer group retiree plan and may provide coverages that are different from a Medicare supplement plan. If you have a Medicare supplement plan, you may not need both the Medicare supplement plan and the employer group retiree plan. If you choose to enroll in this group retiree plan and later decide to enroll in a Medicare supplement plan, acceptance to your Medicare supplement plan application may be subject to medical underwriting. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance.

Underwritten by
UnitedHealthcare Insurance Company

Enrollment Form

(Please Print)

☐ **Senior Supplement**
☐ **Senior Security**

Please complete the entire form ▪ Incomplete information can delay the enrollment process
(Please Print – If you need more room for your answers to any questions, please use a separate sheet of paper.)

Company Name	Effective Date	Source of Enrollment ☐ Open Enrollment ☐ New Retiree

1. Retiree Personal Information

Last Name	First Name	MI	Suffix	☐ Male ☐ Female	Date of Birth (mm/dd/yyyy)
Social Security #	Marital Status:	☐ Single ☐ Divorced [☐ Domestic Partner] ☐ Married ☐ Widow			
Medicare Claim #	Part A Effective Date (mm/dd/yyyy)	Part B Effective Date (mm/dd/yyyy)			Part D Effective Date (mm/dd/yyyy)
Employer Name		Date of (Re)Hire (mm/dd/yyyy)			Date of Retirement (mm/dd/yyyy)
Are you currently on COBRA? ☐ Yes ☐ No If Yes, Qualifying Event		COBRA Qualifying Event Effective Date (mm/dd/yyyy)			
Residence Address		City		State	Zip
Home Telephone #		Alternate Telephone #			[E-mail Address]

If you are currently a resident of an institution (e.g., skilled nursing facility, rehabilitation hospital, etc.), please provide the requested information on the next three lines. Providing this information will not affect your eligibility to enroll.

Institution Name	Date of Admission (mm/dd/yyyy)	Telephone #
Address		
Doctor's Name	Doctor's Telephone #	

2. Dependent Information (List family members to be covered – attach additional sheets if necessary)

Spouse[/Domestic Partner]	Last Name	First Name	MI	Suffix
☐ Male ☐ Female	Date of Birth (mm/dd/yyyy)	Social Security #		
Medicare Claim #	Part A Effective Date (mm/dd/yyyy)	Part B Effective Date (mm/dd/yyyy)		Part D Effective Date (mm/dd/yyyy)
Employer Name		Date of (Re)Hire (mm/dd/yyyy)		Date of Retirement (mm/dd/yyyy)
Are you currently on COBRA? ☐ Yes ☐ No If Yes, Qualifying Event		COBRA Qualifying Event Effective Date (mm/dd/yyyy)		
Residence Address (If different from above)		City	State	Zip
Home Telephone # (If different from above)		Alternate Telephone #		[E-mail Address]

If you are currently a resident of an institution (e.g., skilled nursing facility, rehabilitation hospital, etc.), please provide the requested information on the next three lines. Providing this information will not affect your eligibility to enroll.

Institution Name	Date of admission (mm/dd/yyyy)	Telephone #
Address		
Doctor's Name	Doctor's Telephone #	

WHITE COPY – UNITEDHEALTHCARE YELLOW COPY – EMPLOYER/TRUST PINK COPY – RETIREE

3. Benefit Coordination / Other Insurance Carrier Information

1. Does anyone listed have other health insurance? ☐ Yes ☐ No If Yes, complete Section 1a. – 1e. below.	2. Is anyone listed permanently disabled? ☐ Yes ☐ No If Yes, complete the following: 2a. Name: _____ _____ 2b. Date disability began: _____ (mm/dd/yyyy)	3. Is any dependent listed eligible for Medicare? ☐ Yes ☐ No If Yes, complete the following: 3a. Name: _____ 3b. Medicare Identification #: _____ Part A Effective Date: (mm/dd/yyyy) _____ Part B Effective Date: (mm/dd/yyyy) _____ Part D Effective Date: (mm/dd/yyyy) _____
4. If other than English, please indicate Retiree's primary spoken language:		5. Does the Retiree have a disability affecting his or her ability to communicate or read? ☐ Yes ☐ No

Does anyone listed work or plan to work? Self: ☐ Yes ☐ No Spouse[/Domestic Partner]: ☐ Yes ☐ No

1a. Name	1b. Insurance Company Name	1c. Policy #	1d. Effective Date (mm/dd/yyyy)	1e. Other Employer Name and Address

	SELF	SPOUSE[/DOMESTIC PARTNER]
Is anyone listed currently a State Medicaid recipient?	☐ Yes ☐ No	☐ Yes ☐ No
If yes, State Medicaid number:		

4. Terms and Conditions

On behalf of myself, [and my eligible Dependents,] I am requesting enrollment under the UnitedHealthcare Insurance Company ("UnitedHealthcare") Group Policy offered through my former employer. By signing this Enrollment Form, I agree to and understand the following:

1. All coverage is subject to the terms and conditions of the UnitedHealthcare Group Policy.
[2. My former employer or appointed designee may deduct from my retirement income (including my pension) the employee [and Dependent] contribution required to cover my share of the premium, if any.]
3. UnitedHealthcare or its designee shall have access and use of my medical records or the medical records of my dependents for purposes of utilization review surveys, processing of claims, financial audit or other purposes reasonably related to the performance of this Enrollment Form.
4. Any material omission or intentional misrepresentation in answering the questions on this Enrollment Form may result in the denial of benefits and the termination of my[/or my dependent's] coverage.
5. Coverage shall not begin until acceptance of this Enrollment Form by UnitedHealthcare. [Acceptance will not occur until after UnitedHealthcare validates Medicare coverage and eligibility for coverage under the group retiree plan.] Upon acceptance of this Enrollment Form, UnitedHealthcare shall be bound by the terms of my UnitedHealthcare Group Policy and the Amendments thereto (if applicable).
6. All statements and descriptions in this enrollment form are deemed to be representations and not warranties.
7. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

This is not a Medicare supplement plan. This is an employer group retiree plan and may provide coverages that are different from a Medicare supplement plan. If you have a Medicare supplement plan, you may not need both the Medicare supplement plan and the employer group retiree plan. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance.

I certify that I have read the Terms and Conditions printed on the reverse side of this Enrollment Form and that I accept them and will abide by them. I further certify that the information provided in the Enrollment Form is true and complete to the best of my knowledge and belief.

_____

PRINT RETIREE NAME

_____ _____

RETIREE SIGNATURE **DATE**

FOR OFFICE USE ONLY	**FOR EMPLOYER USE ONLY**
RETIREE ☐YES ☐ NO GROUP # _____ PLAN CODE _____ SPOUSE[/DOMESTIC PARTNER] ☐ YES ☐ NO VERIFICATION: _____ DATE _____/_____/_____ Initial	☐ Enrollee is eligible for retiree coverage Effective Date: _____/_____/_____ _____ Initial

February 17, 2009

Arkansas Insurance Department
Life and Health Division
1200 West Third Street
Little Rock, AR 72201-1904

Re: UnitedHealthcare Insurance Company (UnitedHealthcare)
(NAIC #79413) (FEIN # 36-2739571)
Large Group Health Insurance Policy Form # SRINS-POL, et al

Dear Sir or Madam:

UnitedHealthcare Insurance Company (UnitedHealthcare), a member of the UnitedHealth Group family of companies, is submitting the enclosed large group health policy forms for your review and approval. These forms have never previously been submitted for UnitedHealthcare. This is a group health product that UnitedHealthcare intends to offer to large employers in order to provide coverage for their eligible retirees. An eligible retiree who elects to purchase group health coverage can elect coverage under the Group Health Insurance Certificate. Coverage under the Group Health Insurance Certificate is extended to eligible retirees and to their eligible dependents, spouse or domestic partner who are enrolled in Medicare Parts A and B.

Although coverage is intended for individuals who are eligible retirees of an employer and their eligible dependents, all of whom must be enrolled in Medicare Parts A and B, this is not a Medicare Supplement policy. This is a major medical policy that allows the Policyholder to elect various options (i.e. deductibles, copayments, plan maximums, etc.), and which may include benefits that are in addition to those that would be covered by Medicare or that are in a Medicare Supplement policy. This policy will always include all state mandated benefits that would be required in your state for any large group health plan.

Along with this policy, an employer may choose to purchase additional coverage for Hearing, Vision, Neuromuscular Skeletal Disorders, and/or Outpatient Prescription Drug coverage. The Riders for these additional coverages are included with this filing.

Also included with this filing is the state-required Consumer Information Notice, Guaranty Association Notice, and a Certification of Unfair Sexual Discrimination.

These forms have never previously been submitted for UNITEDHEALTHCARE. However, a similar filing for another one of the United Health Group companies, PacifiCare Life and Health Insurance Company, was submitted to and Filed by your Department on December 5, 2006.

Thank you very much for your consideration of this filing.

Yours truly,

Judith J. Davenport, FLMI, AIRC
Manager, Regulatory Affairs
Voice: (714) 226-3507
Email: judy.davenport@phs.com